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CIVIL DISTRICT COURT FOR THE PARIS OF ORLEANS  
STATE OF LOUISIANA  
DIVISION K  
NO. 96-8461, DOCKET NO. 4  
CLASS ACTION CLAIM

GLORIA SCOTT and DEANIA :  
JACKSON, :

Plaintiffs, :

: Videotaped  
: Deposition of:  
: ALDEN G. COCKBURN, M.D.

THE AMERICAN TOBACCO :  
COMPANY, INC., et al., :

Defendants. :

TRANSCRIPT of testimony as taken by and  
before Cynthia L. Varney, a Shorthand Reporter and  
Notary Public of the State of Florida, at the  
Crowne Plaza Hotel, 700 North West Shore Boulevard,  
Tampa, Florida, on Thursday, October 26, 2000,  
commencing at 9:15 in the morning.

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## 2 WITNESS DIRECT CROSS REDIRECT

3 ALDEN G. COCKBURN, M.D.  
4 Mr. Leger 4 138  
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## 6 EXHIBITS

## 7 NUMBER DESCRIPTION IDENTIFICATION

8 No. P-1 Notice of Deposition 14

9 No. P-2 Curriculum Vitae 16

10 No. P-3 Reliance List 17

11 No. P-4 Expert Report 71

1 ALDEN G. COCKBURN, M.D.,  
2 4700 North Habana Avenue  
3 Tampa, Florida, sworn.

## 4 DIRECT EXAMINATION BY MR. LEEGER:

5 Q. Doctor, my name is Walter Leger, and  
6 I'm, as you know, an attorney representing the  
7 plaintiffs in a case in New Orleans in which you've  
8 been retained as an expert witness. I know and  
9 understand that you've given your deposition  
10 several times before, and therefore I'm assuming  
11 you kind of understand what's going on —

12 A. I do.

13 Q. — in the way of procedure and  
14 otherwise. I'm going to ask you a series of  
15 questions over several hours, and if you don't  
16 understand my question, if there's any  
17 misunderstanding, please let me know. If we're  
18 talking over each other or otherwise, let me know,  
19 too, and — because I assume we're going to have a  
20 tendency to communicate at one point, and as you  
21 know, the court reporter has got to be able to hear  
22 us individually, and separate and apart from each  
23 other.

24 I'm going to ask you, now, to state  
25 your name and your office address, once again, for

1 the record.

2 A. Alden George Cockburn, M.D., 4700  
3 North Habana Avenue, Tampa, Florida 33614.

4 Q. And, Doctor, would you — you have  
5 been deposed before, I understand —

6 A. I have.

7 Q. — correct? About how many times?

8 A. Over 15 times.

9 Q. Okay. Now, have you been deposed in  
10 any other tobacco-related case, other than the  
11 Engles case?

12 A. No, I haven't.

13 Q. Have you, in connection with tobacco  
14 or cigarette litigation, been retained or consulted  
15 in any other matter, other than the Engles case?

16 A. None.

17 Q. So your only association with  
18 cigarette tobacco companies has been your  
19 involvement as an expert witness on behalf of  
20 tobacco companies in the Engles case and now this  
21 case —

22 A. That's correct.

23 Q. — is that correct?

24 MR. WATTLEWORTH: Object to the  
25 form.

<p>6</p> <p>1 MR. LEGER: What's objectionable</p> <p>2 about the form?</p> <p>3 MR. WATTLEWORTH: Association with</p> <p>4 the cigarette and tobacco companies.</p> <p>5 BY MR. LEGER:</p> <p>6 Q. Do you not --</p> <p>7 MR. WATTLEWORTH: He's --</p> <p>8 BY MR. LEGER:</p> <p>9 Q. Are you not here on behalf of</p> <p>10 tobacco companies as an expert witness?</p> <p>11 A. Yes, but not associated with them.</p> <p>12 Q. Do you have trouble, you know --</p> <p>13 does it bother you to be suggested that you're</p> <p>14 associated with the tobacco companies?</p> <p>15 A. Not particularly, no.</p> <p>16 Q. All right. Is there something about</p> <p>17 the word "associated" that bothers us? I'm just</p> <p>18 trying to get the --</p> <p>19 MR. WATTLEWORTH: Well, it's</p> <p>20 misleading, I mean, association with the tobacco</p> <p>21 companies. It's unclear what you mean by</p> <p>22 "associated with tobacco companies." I think his</p> <p>23 response has clarified that, though.</p> <p>24 BY MR. LEGER:</p> <p>25 Q. Okay. I mean, you're paid to be</p>	<p>8</p> <p>1 15 or so other cases that you've testified in</p> <p>2 previously, can you give me an idea of what those</p> <p>3 cases involved?</p> <p>4 A. Usually, independent medical</p> <p>5 evaluations or an expert witness in a malpractice</p> <p>6 litigation.</p> <p>7 Q. Now -- and I have read your previous</p> <p>8 deposition, and I really don't want to go over that</p> <p>9 area in detail, but I just want to make sure that</p> <p>10 there's nothing missing from that deposition, and</p> <p>11 the deposition I'm talking about is the deposition</p> <p>12 you gave in the Engles case; correct?</p> <p>13 A. Correct.</p> <p>14 Q. Have you reviewed that deposition</p> <p>15 recently?</p> <p>16 A. No, I haven't.</p> <p>17 Q. Have you looked at it at any time</p> <p>18 since your testimony in the Engle trial?</p> <p>19 A. No, I haven't.</p> <p>20 Q. You haven't looked at it in</p> <p>21 anticipation of testifying in this deposition</p> <p>22 today?</p> <p>23 A. No, I haven't.</p> <p>24 Q. In that deposition, I understand</p> <p>25 that you had testified in approximately 10</p>
<p>7</p> <p>1 here by --</p> <p>2 A. That's correct.</p> <p>3 Q. -- a tobacco company, right?</p> <p>4 A. That's correct.</p> <p>5 Q. Is it only one company that's paying</p> <p>6 you or is it all of them?</p> <p>7 A. Just one that I know of.</p> <p>8 Q. Which company are you getting a</p> <p>9 check from?</p> <p>10 A. R.J. Reynolds.</p> <p>11 Q. Okay. You think that means you're</p> <p>12 not associated with them, the fact that you're not</p> <p>13 getting money from them?</p> <p>14 MR. WATTLEWORTH: Object to the</p> <p>15 form.</p> <p>16 MR. LEGER: Okay. What's</p> <p>17 objectionable about the form?</p> <p>18 MR. WATTLEWORTH: Well, it's</p> <p>19 argumentative.</p> <p>20 MR. LEGER: Okay.</p> <p>21 BY MR. LEGER:</p> <p>22 Q. You can answer the question.</p> <p>23 A. I have a financial relationship with</p> <p>24 R.J. Reynolds as an expert witness.</p> <p>25 Q. Okay. Now, in connection with the</p>	<p>9</p> <p>1 malpractice cases, either by deposition or</p> <p>2 otherwise?</p> <p>3 A. Yes.</p> <p>4 Q. Okay. And three malpractice cases</p> <p>5 were cases involving claims against you; is that</p> <p>6 correct?</p> <p>7 A. That's correct.</p> <p>8 Q. The other seven were as an expert</p> <p>9 witness on either -- behalf of either the plaintiff</p> <p>10 or the defendant; correct?</p> <p>11 A. That's correct.</p> <p>12 Q. In most cases, you've been retained</p> <p>13 and testified in connection with the defense of a</p> <p>14 doctor accused of malpractice --</p> <p>15 A. That's correct.</p> <p>16 Q. -- correct? How many of those were</p> <p>17 plaintiff?</p> <p>18 A. That is that the doctor was not the</p> <p>19 plaintiff?</p> <p>20 Q. That's correct, where the doctor was</p> <p>21 not the plaintiff.</p> <p>22 A. About three.</p> <p>23 Q. And did you testify in any where the</p> <p>24 doctor was the plaintiff? -- I mean the party</p> <p>25 suing the other party.</p>

<p>10</p> <p>1 A. Yes.</p> <p>2 Q. Okay. And what case was that, where</p> <p>3 the doctor sued someone else?</p> <p>4 A. I'm sorry. I'm confused by the</p> <p>5 legalese.</p> <p>6 Q. The term. That's what I was --</p> <p>7 that's -- right.</p> <p>8 A. No, I haven't --</p> <p>9 Q. Okay.</p> <p>10 A. -- where a doctor sued someone else,</p> <p>11 no.</p> <p>12 Q. All right. Your testimony has been</p> <p>13 on behalf of doctors --</p> <p>14 A. That's correct.</p> <p>15 Q. -- when being sued, generally?</p> <p>16 A. That's correct.</p> <p>17 Q. Otherwise, in a -- I'm sorry. Was</p> <p>18 it three cases you testified for the person suing</p> <p>19 the doctor?</p> <p>20 A. That's correct.</p> <p>21 Q. Have -- since the Engle deposition,</p> <p>22 have you testified in or have you been retained or</p> <p>23 involved in any malpractice cases?</p> <p>24 A. No.</p> <p>25 Q. Since your Engles deposition, have</p>	<p>12</p> <p>1 Q. Okay. I appreciate that, and I</p> <p>2 would like that information, but my question is,</p> <p>3 after the deposition, at the -- either on your own</p> <p>4 or at the request of lawyers of tobacco companies,</p> <p>5 did you do any inquiry into that case?</p> <p>6 A. No, and I don't know why I would.</p> <p>7 Q. Okay. That's what I'm wondering, if</p> <p>8 they asked you to give them information about that</p> <p>9 case.</p> <p>10 A. No.</p> <p>11 Q. Okay. Do you remember who the --</p> <p>12 the names of the lawyers that sued you?</p> <p>13 A. No.</p> <p>14 MR. LEGER: Off the record.</p> <p>15 (Discussion off the record.)</p> <p>16 BY MR. LEGER:</p> <p>17 Q. By the way, did you bring a file</p> <p>18 with you today?</p> <p>19 A. No, I didn't bring anything.</p> <p>20 Q. No? Okay.</p> <p>21 MR. LEGER: Do you have the --</p> <p>22 subpoena, Christine?</p> <p>23 MS. DESUE: Mm-hmm.</p> <p>24 MR. LEGER: Do you have an extra</p> <p>25 copy?</p>
<p>11</p> <p>1 you been involved in any cases whatsoever --</p> <p>2 A. No.</p> <p>3 Q. -- other than this one?</p> <p>4 A. None.</p> <p>5 Q. So may I assume that your testimony</p> <p>6 in the Engles deposition regarding your prior cases</p> <p>7 and prior -- and history of testifying is complete,</p> <p>8 basically --</p> <p>9 A. That's correct.</p> <p>10 Q. -- other than this case and other</p> <p>11 than testifying at the Engle trial; right?</p> <p>12 A. That's correct.</p> <p>13 Q. After your deposition in the Engles</p> <p>14 case, did you go back and try to identify who the</p> <p>15 patients were that sued you? In other words,</p> <p>16 apparently, in Engles, you didn't remember the</p> <p>17 names of two of the three patients that sued you.</p> <p>18 A. Did I go back and --</p> <p>19 Q. Yes, sir.</p> <p>20 A. Which ones are you concerned about?</p> <p>21 Q. Well, all three of them, actually.</p> <p>22 The first one, 1990 or so?</p> <p>23 A. I can certainly get you that</p> <p>24 information. I don't keep it on the top of my</p> <p>25 head.</p>	<p>13</p> <p>1 BY MR. LEGER:</p> <p>2 Q. Have you been shown a copy of this</p> <p>3 notice of deposition with Exhibit A attached?</p> <p>4 A. Yes. Yes, I have.</p> <p>5 Q. When did you get that?</p> <p>6 A. I saw a copy of this yesterday.</p> <p>7 Q. Did you see it before then?</p> <p>8 A. No.</p> <p>9 Q. Okay. So at no time -- at no time</p> <p>10 did you attempt to gather information in connection</p> <p>11 with this particular document that I just showed</p> <p>12 you; correct?</p> <p>13 MR. WATTLEWORTH: Well --</p> <p>14 A. Let me read the document over. I</p> <p>15 didn't --</p> <p>16 MR. WATTLEWORTH: -- for the record,</p> <p>17 you know, we have -- he has gathered information.</p> <p>18 We've produced some of that to you already.</p> <p>19 MR. LEGER: Okay. Well, that's the</p> <p>20 problem, some of it.</p> <p>21 MR. WATTLEWORTH: I'm certain you're</p> <p>22 going to tell us in a minute here. Yeah, right.</p> <p>23 I'm sure you're going to let us know which</p> <p>24 information that is.</p> <p>25 MR. LEGER: Do you have exhibit</p>

14

1 tags? Because I would like to mark the document  
2 that the doctor is reviewing now, which is a notice  
3 of deposition with Exhibit A, which, under the  
4 rules of the case management order and the ruling  
5 of the Special Master are deemed as if submitted as  
6 a subpoena duces tecum. We're going to call that  
7 Cockburn No. 1.

8 THE DEPONENT: "Co-burn."

9 MR. LEGER: I'm sorry.

10 THE DEPONENT: Spelled "Cock-burn";  
11 it's pronounced "Co-burn."

12 MR. LEGER: Cockburn No. 1.

13 MR. WATTLEWORTH: So this is 1, not

14 A?

15 MR. LEGER: Yeah, that's right, the  
16 number 1.

17 BY MR. LEGER:

18 Q. Now, Doctor, you just looked through  
19 this document. Have you provided everything that's  
20 requested in this document No. 1?

21 A. Yes, I have.

22 Q. Okay. And who did you provide those  
23 things to?

24 A. Mr. Wattleworth.

25 Q. Okay. We're going to go through

16

1 manuscript regarding a 25-year experience with  
2 seminoma and regarding spermatocytic seminoma --  
3 seminoma; correct?

4 A. Correct.

5 Q. You would delete the -- they are no  
6 longer in preparation?

7 A. Correct.

8 Q. How long ago were they in  
9 preparation?

10 A. Oh, I was still pursuing them up  
11 until about 1989, 1990.

12 Q. Okay. So by 1990, there were no  
13 longer any manuscripts in preparation?

14 A. That's correct.

15 Q. Okay. And we're going to -- just  
16 for the sake of the record, we're going to attach a  
17 copy of that as -- that curriculum vitae -- as  
18 Cockburn No. 2, and then we're going to talk about  
19 that in a little bit.

20 You also provided what is called a  
21 reliance list; is that correct, Doctor?

22 A. That's correct.

23 Q. And now we're talking about provided  
24 that in June?

25 A. That's correct.

15

1 this. Have you provided a -- back in June, you  
2 issued a report; correct?

3 A. I did.

4 Q. And at that time, you provided the  
5 lawyers for the tobacco companies with a curriculum  
6 vitae; correct?

7 A. I did.

8 Q. Is there an updated version of that  
9 curriculum vitae?

10 A. There is no updated version. I  
11 realize that -- it is a little dated, but  
12 nothing substantially new has occurred since that  
13 was written.

14 Q. So, by "dated," you mean that the  
15 curriculum vitae, even in June, was a little out of  
16 date; is that correct?

17 A. It's a little out of date, yes.

18 Q. So there's just a little more  
19 information --

20 A. No. Actually, I would delete the  
21 information on the last page. Those manuscripts  
22 that were in preparation are -- I guess you could  
23 consider them defunct. They didn't proceed to  
24 publication.

25 Q. Okay. On the fourth page, the

17

1 Q. May I show you this reliance list,  
2 Doctor? And what was this document, which we're  
3 going to mark as Cockburn No. 3?

4 A. That's the bibliography used in  
5 making the report.

6 Q. Have you acquired any further  
7 information or materials since that date which you  
8 consider will be relied upon or important to your  
9 opinions in this case since this was submitted in  
10 June of --

11 A. No.

12 Q. -- 2000? So your entire opinions  
13 are based on what's in this material; correct?

14 A. Well, I have a fund of knowledge  
15 that I bring to the subject that is well beyond  
16 that which is annotated in the bibliography, yes.

17 Q. Now, just for the sake of  
18 clarification, we appear to have been provided --  
19 and it's really, honestly difficult to determine,  
20 but -- a few additional medical journal articles  
21 that are not on this list, I believe we were  
22 provided by counsel for the tobacco companies.

23 A. Okay.

24 Q. So did they get that from you,  
25 something supplemental to this?

18

1 A. Well --

2 MR. WATTLEWORTH: If you -- perhaps  
3 if he's -- I'm sorry. I'm just saying, if you have  
4 those articles that you could identify to him, that  
5 might assist in determining exactly how he came  
6 about acquiring them.

7 BY MR. LEGER:

8 Q. I'm going to show you your article  
9 regarding BTA Quantitative Assay by Casetta, and a  
10 urinary -- another one, a urinary BTA Stat and  
11 other things, by Serretta, et al.

12 A. Mm-hmm.

13 Q. These are things that you have  
14 reviewed since giving your opinion?

15 A. I wouldn't say since giving my  
16 opinion. I probably read these along at the same  
17 time that I prepared that. I just didn't include  
18 them as part of the bibliography.

19 Q. Okay. Where did you get those  
20 articles? In other words, did you go look them up  
21 or were they given to you by tobacco company  
22 lawyers?

23 A. I think these were given to me.

24 Q. Do you know who gave them to you?

25 A. Mr. Wattleworth.

19

1 Q. Okay. And how about -- I'm also  
2 going to show you an article by Welch, et al., from  
3 Journal of the American Medical Association, Are  
4 Increasing Five Year Survival Rates Evidence of  
5 Success Against Cancer?

6 MR. WATTLEWORTH: Let's go off the  
7 record for a second.

8 (Discussion off the record.)

9 MR. LEGER: And let's just clarify  
10 that on the record.

11 MR. WATTLEWORTH: Sure, yeah.

12 BY MR. LEGER:

13 Q. As I appreciated, the JAMA article  
14 that you just looked at by Welch is not an article  
15 that you have reviewed in formulating your  
16 opinions; is that correct?

17 A. Or I've seen before; that's correct.

18 Q. It was never provided to you by  
19 anybody but me at this deposition?

20 A. That's correct.

21 Q. Okay. And apparently it was  
22 mistakenly provided to us, suggesting that you  
23 relied upon it; correct?

24 A. That's correct.

25 Q. All right. The other two, however,

20

1 were provided to you by lawyers for the tobacco  
2 company?

3 A. That's correct.

4 Q. Okay.

5 MR. WATTLEWORTH: And those  
6 being -- what? -- the Casetta article and --

7 MR. LEGER: Casetta and Serretta  
8 articles, et al.

9 MS. DESUE: And there's two --

10 BY MR. LEGER:

11 Q. And there are two additional  
12 articles, one Comparative Sensitivity of Various  
13 Tests, Including NMP-22, by Marta Sanchez-Carbayo,  
14 and a Comparative Evaluation of Various Tests,  
15 Including NMP-22, by Giannopoulos, et al. Those  
16 are not on your reliance list, and I'm wondering if  
17 you have also seen those and were they also  
18 provided to you by lawyers for the tobacco  
19 companies or a lawyer for the tobacco companies?

20 A. I read this article in the Journal,  
21 and I don't remember -- I honestly don't remember  
22 where -- if I saw this one outside of the Journal  
23 and --

24 Q. Which one are you referring to?

25 A. This one in the Journal of Urology,

21

1 Comparative Sensitivity by Marta Sanchez-Carbayo.  
2 This one from Adult Urology, the Comparative  
3 Evaluation of the BTA Stat Test, I think I read  
4 this one, and this was provided by the tobacco  
5 company.

6 Q. Okay. Now, you say you may have --  
7 did you make copies, though, and send these as if  
8 to be provided to us?

9 A. I didn't make --

10 Q. Okay.

11 A. -- copies, no.

12 MR. LEGER: And we don't need to  
13 even identify them, unless you would prefer us to.

14 MR. WATTLEWORTH: No.

15 MR. LEGER: I'm just trying to  
16 get --

17 MR. WATTLEWORTH: I think, since  
18 we've identified the authors --

19 MR. LEGER: Yeah.

20 MR. WATTLEWORTH: -- we have an idea  
21 of what we're talking about.

22 BY MR. LEGER:

23 Q. Now, in connection with the articles  
24 that we just spoke about, the four articles we  
25 spoke about that are not listed in here, you saw

<p>22</p> <p>1 those articles after — after your opinions were 2 given in this report?</p> <p>3 A. Possibly, yes.</p> <p>4 Q. Did they materially affect your 5 opinion in any way?</p> <p>6 A. No.</p> <p>7 Q. Change it, modify it, otherwise?</p> <p>8 A. No. It's just additional data.</p> <p>9 MR. LEGER: Chris, I think I've 10 numbered these right.</p> <p>11 MS. DESUE: Yes.</p> <p>12 BY MR. LEGER:</p> <p>13 Q. Now, other than the articles that 14 we've talked about and the articles on Cockburn 15 No. 3, the 16 or so documents and articles, are 16 there any other materials, documents, writings, 17 databases, otherwise, that you relied on in 18 formulating opinions, other than general — the 19 general body of —</p> <p>20 A. No.</p> <p>21 Q. — of knowledge?</p> <p>22 A. Other than the general body of 23 knowledge that's available, no.</p> <p>24 Q. Did you particularly rely upon, 25 perhaps any treatises or textbooks in</p>	<p>24</p> <p>1 A. None that I'd specifically want to 2 mention, no.</p> <p>3 Q. Okay. And you consider that 4 Campbell's Urology; that textbook, is 5 authoritative?</p> <p>6 A. I do.</p> <p>7 Q. Is it a textbook which you rely upon 8 regularly in the context of your practice?</p> <p>9 A. I do, as a reference.</p> <p>10 Q. Are there any other references that 11 you consider important in your ordinary practice?</p> <p>12 A. Other than the journals, no.</p> <p>13 Q. Which journals do you consider 14 important?</p> <p>15 A. Urology, Journal of Urology, 16 Investigative Urology, Contemporary Urology.</p> <p>17 Q. Are there any particular journals 18 that you consider important and reliable in the 19 context of oncology?</p> <p>20 A. Yes; Cancer, CA, the cancer journal 21 put out by the ACS, Oncology News.</p> <p>22 Q. Do you prescribe — I'm sorry — 23 subscribe to any of these publications?</p> <p>24 A. I do.</p> <p>25 Q. Do you subscribe to all of them,</p>
<p>23</p> <p>1 particular — in particular language in treatises 2 and textbooks in formulating those opinions?</p> <p>3 A. No.</p> <p>4 Q. Are there any particular —</p> <p>5 MR. WATTLEWORTH: I've got a 6 question. Are you talking about outside of what's 7 listed on his reference list?</p> <p>8 MR. LEGER: Outside of what's listed 9 on his —</p> <p>10 MR. WATTLEWORTH: Okay.</p> <p>11 MR. LEGER: — on the reliance.</p> <p>12 MR. WATTLEWORTH: Because Campbell's 13 Urology is listed on there.</p> <p>14 MR. LEGER: Yes, mm-hmm.</p> <p>15 THE DEPONENT: Well, that's — no. 16 Outside of that, no.</p> <p>17 BY MR. LEGER:</p> <p>18 Q. And there are a number of other 19 texts in — texts in urology and in uro-oncology, I 20 assume; correct?</p> <p>21 A. That's correct.</p> <p>22 Q. Are there any particular texts, 23 other than Campbell's Urology, that you consider 24 authoritative in the context of what we're talking 25 about in this case?</p>	<p>25</p> <p>1 basically, that you just listed?</p> <p>2 A. No. I subscribe to Urology, 3 Contemporary Urology. The others I read in — 4 either on the Internet or the library.</p> <p>5 Q. So you do not subscribe to any of 6 the cancer journals?</p> <p>7 A. No, I don't.</p> <p>8 Q. Or oncology materials; correct?</p> <p>9 A. Correct.</p> <p>10 Q. Have you been provided with copies 11 of any medical records pertaining to Gloria Scott 12 and Deania Jackson?</p> <p>13 A. No, I haven't.</p> <p>14 Q. Do you expect to be provided any 15 such records?</p> <p>16 A. No.</p> <p>17 Q. Have you asked for records?</p> <p>18 A. No.</p> <p>19 Q. Do you know who Gloria Scott and 20 Deania Jackson are?</p> <p>21 A. No, I don't.</p> <p>22 Q. Do you — this subpoena requested 23 your billing records. Have you provided a copy of 24 those billing records?</p> <p>25 A. I don't think I have, because I just</p>

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1 submitted a bill maybe a month ago.

2 Q. Do you remember what that bill was  
3 for, in terms of how much?

4 A. About \$3,000.

5 Q. And how much are you charging in  
6 this case?

7 A. I think it's on the report, \$300 for  
8 a deposition, or 350, something like that.

9 Q. Okay. If I told you were — you  
10 said you were charging 350 for consultation and  
11 \$500 for a deposition, would that surprise you?

12 A. No, but it would sound better.

13 Q. Doctor, in the Engles case, you  
14 testified that you were charging \$250 an hour —

15 A. Uh-huh.

16 Q. — is that correct?

17 A. Yes. Inflation has been going up.

18 Q. So do you consider that it's a  
19 result of inflation that you've increased your fees  
20 or are you more expert now?

21 A. I've increased my fees not because  
22 I'm more expert, just because of the hassle factor,  
23 maybe.

24 Q. Explain the hassle factor, sir.

25 A. Just it's not medicine. It's not

28

1 something as was named here, the NMP-22, as the  
2 specific test of choice for an evaluation that has  
3 already been established as a — the normative way  
4 of approaching someone with blood in the urine.

5 Q. Okay. Explain that. You object to  
6 the monitoring program?

7 A. Oh, no. No, not at all do I  
8 disagree with the monitoring program. I think we  
9 have to have a monitoring program. I disagree with  
10 the form.

11 Q. Okay. Let's talk about that. You  
12 agree, it is your opinion that a monitoring program  
13 to attempt to detect bladder cancer at an early  
14 stage is good, sound medicine and science —

15 A. Absolutely.

16 Q. — correct? Where we — where you  
17 disagree is the particular methodology of the  
18 program proposed —

19 A. That's correct.

20 Q. — by the scholars and doctors and  
21 professors in the state of Louisiana?

22 A. That's correct.

23 Q. Okay. Can you explain to me  
24 particularly what it is you disagree with?

25 A. The form, as I see it, implies that

27

1 what I'm used to. It's not what I like. It's not  
2 pleasant.

3 Q. Why did you agree to do it?

4 A. Partly because I think that, as I  
5 was in the Engle case, I feel strongly about one's  
6 need to accept responsibility for one's actions  
7 and — instead of blaming outside forces, like  
8 addiction and things like that, for things that we  
9 do.

10 Q. What does that have to do with your  
11 testimony as an expert urologist?

12 A. Well, in this case, as was presented  
13 for screening for bladder cancer, I disagreed with  
14 the proposal as it was and I didn't think that that  
15 was good medicine, and that's the main reason.

16 Q. Do you have an idea of better  
17 medicine?

18 A. I think so.

19 Q. Okay. What is that?

20 A. I think that it involves a screening  
21 method that is based on a routine examination that  
22 we all do, and that is a urinalysis, and that it  
23 should be followed by the same normative practices  
24 that we do for anyone with an abnormal urinalysis;  
25 and I don't think that we specifically have to name

29

1 individuals who — as I understand it, who have  
2 been exposed to tobacco smoke by smoking themselves  
3 are therefore susceptible to developing bladder  
4 cancer, and therefore, as I understand it, all of  
5 those individuals deemed potentially vulnerable  
6 ought to be evaluated by the methods that were  
7 described; and I take issue with only one of those  
8 tests.

9 Q. Which test?

10 A. The NMP-22.

11 Q. Okay. So do I understand, then —  
12 and I'm really just trying to establish our points  
13 of agreement so we can talk about what we disagree  
14 on. Do I understand that you agree that persons  
15 who are exposed to tobacco smoke by smoking should  
16 be monitored for bladder cancer?

17 A. As anyone over the age of 50 should  
18 be, yes.

19 Q. Well, do you — let me see if I can  
20 make sure we understand each other. Is it your  
21 testimony that everyone, whether they smoke or not,  
22 should be monitored for bladder cancer?

23 A. It depends on what you mean by  
24 "monitored." We monitor individuals when they  
25 present to us for a physical examination by looking



30

1 at their urine. Is that cancer detection or is  
2 that monitoring?

3 Q. Okay. Let's factor out a physical  
4 examination because -- let's talk about the  
5 physical examination aspect. There is no organized  
6 program that allows for funding of regular physical  
7 examinations; is that correct -- in America?

8 A. No, that's correct.

9 Q. No, there is no program?

10 A. That's correct; there is no program.

11 Q. Is there a program for monitoring  
12 for individuals in the population with no  
13 particular risk factors in the state of Florida?

14 A. When you say "a program," that means  
15 sponsored by --

16 Q. Someone paying for it.

17 A. No.

18 Q. Are you aware of such a program in  
19 the state of Louisiana?

20 A. No.

21 Q. Is there a recommendation by any  
22 medical associations or health care organizations  
23 for such program?

24 A. I don't know of one.

25 Q. Okay. I mean, in Florida or

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1 Louisiana or in the United States of America,  
2 you're not aware of any; correct?

3 A. No, I'm not.

4 Q. Or in any other country in the  
5 world, is that correct? -- You're not aware.  
6 There may be, but you're not aware; correct?

7 A. There may be, but I'm not aware.

8 Q. Okay. Now, so generally what you  
9 suggest is that, however, if a person is seen in a  
10 doctor's office for an examination on an ordinary  
11 basis, one of the things that they should be tested  
12 for is urinalysis -- or a urinalysis should be  
13 done?

14 A. That depends on how general and  
15 specific you want to make the word "examination."  
16 If they're coming in for an annual examination,  
17 yes, I think that should be. If they're coming up  
18 for a follow-up on their heart medicine, no.

19 Q. The fact of the matter is, though,  
20 Doctor -- and I don't really mean to quibble with  
21 you, though, but -- in the context of the health  
22 care system in the United States of America, it is  
23 not ordinary for Americans to simply come in  
24 annually for a, quote, physical examination; isn't  
25 that true?

32

1 MR. WATTLEWORTH: Object to the  
2 form.

3 A. We advocate it.

4 BY MR. LEGER:

5 Q. Who is "we"?

6 A. The medical community advocates that  
7 everyone over the age of 50 should be seen by a  
8 doctor on an annual basis.

9 Q. Okay. Where do you advocate it and  
10 how do you advocate it?

11 A. Daily to my patients.

12 Q. To your --

13 A. It's not done through -- I don't  
14 know of the American Medical Association having a  
15 policy like this or that has been advertised as  
16 such, but it is certainly practiced on a daily  
17 basis, I think, by most physicians, who recommend  
18 that over a certain age, individuals should be  
19 examined at least once a year.

20 Q. What we know is, though, that it is  
21 a clear, minuscule minority of people in America  
22 that do go in for annual physicals; isn't that  
23 true?

24 MR. WATTLEWORTH: Object to form. --

25 A. We don't have a national health

33

1 system.

2 BY MR. LEGER:

3 Q. Exactly. But, I mean, the point is,  
4 Doctor, that -- I mean, you would agree, though,  
5 that a very small minority of people in America do  
6 go in for annual physicals; isn't that right?

7 MR. WATTLEWORTH: Object to the  
8 form.

9 A. I don't know -- I don't know that I  
10 would say a small minority.

11 BY MR. LEGER:

12 Q. Would you say a medium minority?

13 MR. WATTLEWORTH: Object to the  
14 form. What do you mean by "medium minority"?

15 MR. LEGER: I don't know. That's  
16 what I'm trying to find out, what he knows.

17 BY MR. LEGER:

18 Q. Is -- the next one is a large  
19 minority? I --

20 A. It depends on population groups,  
21 income strata, all of those. Most people don't go  
22 to a doctor unless they have a complaint.

23 Q. Exactly.

24 A. Yes.

25 Q. And, Doctor, there are, however,

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1 some companies that will pay for annual physicals  
2 by employees; correct?

3 A. That's correct.

4 Q. There are some programs that allow  
5 for payment of annual physicals; correct?

6 A. That's correct.

7 Q. The — if an individual walks in off  
8 the street to a doctor's office, under the current  
9 American health care system, and says, I want a  
10 physical examination, will most insurance companies  
11 pay for the physical examination?

12 A. Yes.

13 Q. Even with no symptoms, no  
14 symptomology?

15 A. That's correct.

16 Q. Okay. When a person comes into a  
17 family practitioner's office for a physical  
18 examination, what does the doctor do, ordinarily?

19 A. An asymptomatic individual comes  
20 into the doctor and says, I'd like to have a  
21 physical exam?

22 Q. Mm-hmm.

23 A. I think he gets a physical  
24 examination; he gets a urinalysis; most likely,  
25 he'll get some blood work — a CBC, a basic

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1 whether they're paying for it themselves or whether  
2 their insurance companies are paying for it?

3 A. I do know. I know that most of them  
4 do pay a co-payment but that the insurance company  
5 pays for the procedure.

6 Q. Okay. Now, do you know, in the case  
7 of those patients that come in for annual  
8 physicals, whether they're part of a particular  
9 employer group program or otherwise?

10 A. No. I think that most of them do  
11 not have a — the program you describe.

12 Q. Okay. Now, let's get back to this  
13 particular program. You believe that, in  
14 connection with a physical examination, it is  
15 entirely appropriate and proper and medically sound  
16 to perform a urinalysis even in a person who has no  
17 particular known risk to bladder cancer; correct?

18 A. Absolutely.

19 Q. Okay. And what are you looking for  
20 in a urinalysis?

21 A. What do you look for in a  
22 urinalysis?

23 Q. Yes, sir.

24 A. Glucose, ketones, bilirubin, blood,  
25 leukocytes, nitrite, protein.

35

1 metabolic profile — and then, depending, he may  
2 get an EKG; and depending on his age or her age,  
3 they may have a colonoscopy.

4 Q. So does he get a cystoscopy (sic)?

5 A. Cystoscopy?

6 Q. Cystoscopy.

7 A. No, unless indicated by blood in the  
8 urine.

9 Q. And in your testimony that  
10 insurance companies will pay for all of those tests  
11 without evidence of symptom?

12 MR. WATTLEWORTH: Object to the  
13 form.

14 A. I honestly don't know. My  
15 impression is that they do, simply because I see a  
16 fair number of patients who do come in annually  
17 with no complaints, just for a checkup, and I  
18 haven't heard any complaints from them that the  
19 insurance company did not pay for it or would not  
20 pay for it or that they were afraid that the  
21 insurance company would not pay for it.

22 BY MR. LEGER:

23 Q. Okay. So the fact of the matter is  
24 that you don't know whether, in the case of your  
25 patients who come in for an annual physical —

37

1 Q. And what are you looking for in the  
2 context of attempting to determine bladder cancer?

3 A. Blood or protein.

4 Q. Now, with respect to further  
5 analysis — and you're talking about in the context  
6 of what you think is normal, a group with no  
7 risk — now assume you do a urinalysis and you find  
8 blood work which is suggestive of possible bladder  
9 cancer; correct?

10 A. Not blood work; you find blood in  
11 the urine.

12 Q. You find hematuria.

13 A. Correct.

14 Q. You find blood in the urine. And  
15 then blood in the urine suggests what to you?

16 A. Suggests an abnormality that needs  
17 to be evaluated.

18 Q. Okay.

19 A. It's a red flag.

20 Q. So now you have taken a population  
21 of people who have no particular high risk for any  
22 particular disease — and we're talking  
23 theoretically — and now, however, once you find  
24 hematuria, or blood in the urine, they are at high  
25 risk for something —

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1 A. That's correct.  
2 Q. -- correct? And you would suggest  
3 that they were -- and I'm not -- I'm leading you,  
4 really, to try to get to the point. You would  
5 agree, though, then, that they are high risk for a  
6 number of abnormalities, including bladder  
7 cancer --  
8 A. That's correct.  
9 Q. -- correct? And what are those  
10 potential problems that hematuria is suggestive of?  
11 A. Across the board, male and female,  
12 it would be stones in the collecting system, some  
13 congenital abnormality, infection, and then bladder  
14 cancer, and then for men, in particular, benign  
15 prostatic hypertrophy.  
16 Q. What is benign prostatic  
17 hypertrophy?  
18 A. It's something that you and I have  
19 and will get worse from as time goes on because the  
20 prostate grows in response to trophic stimulation  
21 from the testosterone, the male hormone.  
22 Q. Okay. So at that point before you  
23 do the urinalysis, and in the context of bladder  
24 cancer, the general population is certainly,  
25 obviously, not at any particular high risk for

1 and the cytokines, etc.  
2 Q. The things mentioned in your report,  
3 the --  
4 A. That's correct.  
5 Q. -- FDP, the vascular endothelial  
6 growth factor; you're looking for molecular  
7 prognostic markers in P 53 gene, etc.; correct?  
8 A. That's correct.  
9 Q. Ordinarily, would you run all of  
10 those tests?  
11 A. No, no, not at all. Most of those  
12 are investigate -- investigative -- are in the  
13 process of being investigated. They are used in  
14 major teaching institutions, really, at this  
15 point -- not -- when I say "used," they're being  
16 evaluated. No one really is using them in a  
17 clinical basis because their reliability is  
18 certainly in question, and that's what this is all  
19 about.  
20 Q. Okay. That's where we're trying to  
21 get to. Your step, after seeing hematuria, would  
22 be, rather than running -- in a typical clinical  
23 setting -- would be, rather than running an NMP-22  
24 or a BTA Stat or an FDP or Telomerase assay or --  
25 otherwise, would be cystoscopy; right?

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1 bladder cancer, correct?  
2 A. That's correct.  
3 Q. All right. Now, once you have  
4 determined that there's hematuria, the general --  
5 that population -- or that person who has hematuria  
6 is now determined to be at high risk for stones,  
7 congenital abnormalities, infection, bladder  
8 cancer, benign prostatic --  
9 A. Hypertrophy.  
10 Q. --hypertrophy?  
11 A. Not high risk, but high suspicion.  
12 Q. Okay. And the next step is what?  
13 A. We follow an algorithm to evaluate  
14 the entire urinary tract. We do an IVP, an  
15 intravenous pyelogram, to delineate the upper  
16 collecting system and the ureter; and then we look  
17 into the bladder cystoscopically with a cystoscope,  
18 and then that gives direct visualization of the  
19 bladder, the prostate, and the urethra. We obtain  
20 a urine specimen for cytologic evaluation, and we  
21 send off a urine culture.  
22 Now, we're exploring the use of  
23 various tumor markers that have been identified  
24 through molecular biological techniques, and among  
25 which are the NMP-22 and the BTA and the Telomerase

1 A. Cystoscopy, absolutely.  
2 Q. And you would also have cytology  
3 performed on the --  
4 A. On every one of them.  
5 Q. -- urine sample?  
6 A. And I want to add, I would also --  
7 if I had them available to me, I would use these  
8 other tests, as I am presently using the BTA.  
9 Okay? The problem is the expense of these tests  
10 and whether or not the insurance company will pay  
11 for them.  
12 Q. All right. So you say you would use  
13 them because you believe -- and you've looked at  
14 the articles -- you believe that they have reached  
15 sufficient scientific acceptability?  
16 MR. WATTLEWORTH: Object to the  
17 form.  
18 BY MR. LEGER:  
19 Q. Correct?  
20 A. I think that they have reached --  
21 certainly, they've reached -- as far as the  
22 NMP-22 -- have reached regulatory acceptability by  
23 the FDA, so they have approved it for that.  
24 Again, the problem comes down to  
25 utility and cost, and it is used adjunctively with

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1 the other established methods.

2 Q. Mm-hmm.

3 A. So the BTA and the NMP-22 are used  
4 but, again, as an adjunct to these others.

5 Q. And I guess that's my question. Do  
6 you have any objection to the use of BTA Stat as a  
7 diagnostic tool?

8 A. I do.

9 Q. Okay. What is that?

10 A. A high failure rate, both in terms  
11 of false positives in patients with hematuria and  
12 false negatives in those patients who have fairly  
13 well differentiated low grade tumors.

14 Q. Do you think BTA Stat, in your mind,  
15 is insufficiently specific in low grade tumor?

16 A. It's sensitive for low grade tumor.

17 Q. It is sensitive?

18 A. In -- not sufficiently sensitive for  
19 low grade tumors.

20 Q. But is -- has been -- but is  
21 sufficiently sensitive in invasive tumors --

22 A. Yes.

23 Q. -- correct? Okay. What about  
24 NMP-22 regarding low grade tumor?

25 A. A little better than BTA, but it's

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1 sometimes not as good as regular urine cytology.

2 Q. Okay. And what about in invasive  
3 tumor?

4 A. Invasive tumor, they -- it tends to  
5 track well, with a higher specificity and  
6 sensitivity, and in that case, better than urine  
7 cytology.

8 Q. Now, you note that the plan  
9 recommended by the doctors in Louisiana calls for  
10 both NMP-22 and cytology; correct?

11 A. That's correct.

12 Q. Do you have an opinion as to the  
13 usefulness of those two items together?

14 A. Oh, I think that they're -- they are  
15 additive and synergistic.

16 Q. So basically, would you agree that  
17 they effectively complement each other?

18 A. They do.

19 Q. They fill the weakness of each  
20 other; correct?

21 MR. WATTLEWORTH: Object to the  
22 form.

23 BY MR. LEGER:

24 Q. Is that your opinion?

25 A. Yeah, for a price.

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1 Q. What is the price?

2 A. I don't know what, specifically, the  
3 price is for the NMP-22. I know for urine cytology  
4 ranges anywhere from about \$120 to up to \$300,  
5 depending on what you get with your study and  
6 who -- what company does it.

7 Q. Okay. How much does a -- strike  
8 that.

9 What would be a reasonable price?

10 What would be a price that would make it worthwhile  
11 to you to use it?

12 A. Something that the government and  
13 the insurance companies would pay for. -

14 Q. Okay. Under \$100 for cytology?

15 A. Well, you know, it's nice to throw  
16 out a figure, but it's a matter of preparation.

17 The cytologist has to see it, and then it has to be  
18 reviewed by a cytopathologist, so there are a lot  
19 of steps in there, and that's what adds the cost  
20 into it.

21 Q. Now, a cytologist is a technician,  
22 basically; correct?

23 A. Yes.

24 Q. And a --

25 A. A highly skilled technician.

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1 Q. And a cytopathologist, is that a  
2 doctor --

3 A. Yes.

4 Q. -- medical doctor?

5 Okay. Doctor, I want you to take  
6 the cost factor out now.

7 A. Mm-hmm.

8 Q. Assume, hypothetically, that cost is  
9 not a factor. Would you agree that the two of  
10 these tests, used together, are effective and would  
11 be recommended for attempting to monitor for  
12 bladder cancer?

13 A. In what individuals?

14 Q. In an individual in whom hematuria  
15 is found.

16 A. Oh, yes. Yes, I think there's a  
17 clear role for both of those there, or some tests  
18 as good or better than the NMP, yes. The reason we  
19 have the NMP is because of the failings of the  
20 cytology, so if we find something that's better  
21 than, across the board, we're going to use it.

22 Q. Are the other tests that you talk  
23 about -- BTA Stat, FDP, Telomerase assay, and  
24 others -- are those complementary with cytology?  
25 Are any of those any better than NMP-22?

<p>46</p> <p>1 A. Well, you see, as you might gather</p> <p>2 from the gist of my article, they're all out there</p> <p>3 and being evaluated at the present time and being</p> <p>4 compared against each other in the same</p> <p>5 populations, and we find that there's such a</p> <p>6 variance in their sensitivity and their specificity</p> <p>7 reported by different groups around the country and</p> <p>8 outside of the country that it's hard for the</p> <p>9 clinician to say at any one point in time that this</p> <p>10 one is better than this one.</p> <p>11 And so at the present time, since</p> <p>12 basically the only -- the NMP-22 and the BTA are</p> <p>13 available to the average clinician, the others are</p> <p>14 basically investigative things.</p> <p>15 Q. And what you're saying is, those two</p> <p>16 have been avail -- they're available to the average</p> <p>17 clinician in terms of they've been approved for use</p> <p>18 by the FDA; is that correct?</p> <p>19 A. That's correct.</p> <p>20 MR. WATTLEWORTH: Object to the</p> <p>21 form.</p> <p>22 BY MR. LEGER:</p> <p>23 Q. The others have -- I'm sorry. Have</p> <p>24 BTA and been approved by use in a clinical doctor</p> <p>25 by the FDA?</p>	<p>48</p> <p>1 form.</p> <p>2 A. As far as I know, it is approved for</p> <p>3 use, yes, by the FDA.</p> <p>4 MR. LEGER: What was objectionable</p> <p>5 about the form?</p> <p>6 MR. WATTLEWORTH: What type of use?</p> <p>7 BY MR. LEGER:</p> <p>8 Q. Okay. Is the -- let's see if we can</p> <p>9 straighten this out. Is the NMPA test approved as</p> <p>10 a diagnostic tool for urologists to detect bladder</p> <p>11 cancer?</p> <p>12 A. Yes, it is.</p> <p>13 Q. By the FDA; correct?</p> <p>14 A. (Deponent nods head.)</p> <p>15 Q. Okay. And it is available to you,</p> <p>16 as a urologist, for use in your office in</p> <p>17 attempting to detect bladder cancer; correct?</p> <p>18 A. That's correct.</p> <p>19 Q. Okay. Now, in the context of what</p> <p>20 we talked about, and you provided us -- actually,</p> <p>21 you provided yourself with, or someone provided to</p> <p>22 you -- a number of articles regarding these various</p> <p>23 tests, and those articles apparently investigated</p> <p>24 the efficacy and the usefulness and the accuracy of --</p> <p>25 the various tests we've talked about; correct?</p>
<p>47</p> <p>1 A. It is -- I don't know if it is --</p> <p>2 actually, I don't know if it is FDA approved. I</p> <p>3 know it is available, and I have it in my office --</p> <p>4 Q. Okay.</p> <p>5 A. -- so I assume that --</p> <p>6 Q. And "available" means there's</p> <p>7 nothing wrong with you using it?</p> <p>8 A. That's correct.</p> <p>9 MR. WATTLEWORTH: Object to the</p> <p>10 form.</p> <p>11 BY MR. LEGER:</p> <p>12 Q. Does it have to be FDA approved for</p> <p>13 you to use it?</p> <p>14 A. I don't think so.</p> <p>15 Q. I mean, it doesn't hurt anybody --</p> <p>16 A. No.</p> <p>17 Q. -- if you use it; right? It's a</p> <p>18 laboratory test?</p> <p>19 A. But FDA approval is what the</p> <p>20 insurance companies look for, for their willingness</p> <p>21 to pay for it.</p> <p>22 Q. Okay. Now, is the NMP-22 use</p> <p>23 approved by the FDA?</p> <p>24 A. It is, yes.</p> <p>25 MR. WATTLEWORTH: Object to the</p>	<p>49</p> <p>1 A. Correct.</p> <p>2 Q. And you just testified a few minutes</p> <p>3 ago that there are mixed results in terms of the</p> <p>4 efficacy of those tests relative to each other --</p> <p>5 A. Correct.</p> <p>6 Q. -- correct? Generally, though, each</p> <p>7 one of those that you referred to in your report</p> <p>8 has been found to be relatively effective; correct?</p> <p>9 MR. WATTLEWORTH: Object to the</p> <p>10 form.</p> <p>11 A. Of some value.</p> <p>12 BY MR. LEGER:</p> <p>13 Q. Of some value, right. And -- but</p> <p>14 the question in the literature that you spoke of</p> <p>15 is, what is the relative effectiveness to each</p> <p>16 other; correct?</p> <p>17 A. That's correct.</p> <p>18 Q. Okay. Now, in the context of</p> <p>19 monitoring for bladder cancer in a person who has</p> <p>20 been found to have hematuria or -- strike that.</p> <p>21 In the context of monitoring for</p> <p>22 bladder cancer in a population of persons who have</p> <p>23 been found to have hematuria, is a cystoscope a</p> <p>24 recommendable tool?</p> <p>25 A. Absolutely, to the point of being</p>

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1 indispensable.  
 2 Q. And why is that?  
 3 A. Well, what's better than direct  
 4 visualization?  
 5 Q. Explain a cystoscope, if you would.  
 6 A. Well, cystoscopy presently is  
 7 performed most often with a flexible cystoscope. A  
 8 cystoscope has the diameter of about 18 french,  
 9 which is a little smaller than this pen.  
 10 Q. Okay.  
 11 A. It's introduced into the urethra  
 12 after it's anesthetized with Xylocaine, and because  
 13 it is flexible, it's far more comfortable than that  
 14 which was used up till maybe even five years ago,  
 15 which was a rigid rod that you accommodated to  
 16 rather than it to you and, as such, it's now done  
 17 as an outpatient --  
 18 Q. I'm sorry, Doctor.  
 19 A. There's nothing nice that happens in  
 20 a doctor's office.  
 21 Q. Right.  
 22 A. It's all uncomfortable and --  
 23 Q. Particularly this.  
 24 A. Well, I tell my patients every day,  
 25 there's nothing pleasant that happens in a doctor's

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1 a -- I mean, you're simply extending your normal  
 2 view, correct?  
 3 A. Correct.  
 4 Q. Can you magnify what you're looking  
 5 at?  
 6 A. It's magnified ten times.  
 7 Q. Okay. And you visually examine the  
 8 wall of the bladder --  
 9 A. That's correct.  
 10 Q. -- when you do that? There's a  
 11 little light, I assume, that you can --  
 12 A. Very powerful light.  
 13 Q. Very powerful light --  
 14 A. Fiber optic.  
 15 Q. -- so that you can see it. And  
 16 there are very observable physical characteristics  
 17 of malignant tumor?  
 18 A. That's correct.  
 19 Q. Okay. Would you agree with the  
 20 general proposition that the earlier you can detect  
 21 the presence of malignant tumor, the better the  
 22 prognosis?  
 23 A. That's a truism; that's correct.  
 24 Q. Okay. And that's a general truism  
 25 in the context of oncology; correct?

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1 office.  
 2 Q. That's true.  
 3 A. Okay? You don't go there for that.  
 4 So with that acknowledgment, you accede to it. The  
 5 telescope is then advanced beyond the prostate into  
 6 the bladder in the male, just simply into the  
 7 bladder through a short urethra in the female, and  
 8 you're able to investigate the entire circumference  
 9 of the bladder, mainly because your cystoscope is  
 10 very flexible at the tip. Rather than being rigid  
 11 and having to use oblique fenses and things like  
 12 that, you can now inspect every bit of it.  
 13 So not only do you know that the  
 14 patient has a tumor, but you know the location of  
 15 the tumor and the characteristics of the tumor, its  
 16 proximity to the uretral orifices when you're  
 17 considering resecting it, etc., etc., etc.  
 18 Q. Okay. So in other words, when you  
 19 use a cystoscope, I mean, you're looking in a  
 20 camera that's looking inside the bladder, correct?  
 21 A. You can. You can. My -- I have an  
 22 attachment -- a camera that attaches to it so the  
 23 patient can see on the video what we're looking at  
 24 or you can look directly into the lens yourself.  
 25 Q. I'm sorry. It's almost like using

53

1 A. That's correct.  
 2 Q. And not just bladder cancer;  
 3 correct?  
 4 A. You can say that about all medicine.  
 5 Q. Okay. So would you also agree with  
 6 the general proposition that in the context of  
 7 malignant tumors, the earlier you find -- you  
 8 observe the tumor, generally, the smaller it is?  
 9 MR. WATTLEWORTH: Are you talking  
 10 about bladder tumors?  
 11 MR. LEGER: I'm talking about tumors  
 12 in general -- cancer tumors in general.  
 13 BY MR. LEGER:  
 14 Q. I mean, the cancer doesn't get  
 15 smaller as it gets worse; correct?  
 16 A. Okay. Cancer is not cancer is not  
 17 cancer.  
 18 Q. Okay.  
 19 A. Okay? There are grades of tumor.  
 20 There are different types of tumors.  
 21 Q. Right.  
 22 A. And there are certain tumors -- 80  
 23 percent of bladder tumors are superficial and don't  
 24 go on to anything more than that, so in that  
 25 context, you may look at a tumor now and come back

<p>54</p> <p>1 a year later and it'll be the same size.</p> <p>2 Q. Okay.</p> <p>3 A. That's its natural history. It's</p> <p>4 not going to grow any more than that. The</p> <p>5 potential for invasion is there, and since we have</p> <p>6 no ability to detect whether or not that is going</p> <p>7 to be invasive, yes, we do attack it at that time</p> <p>8 and remove it.</p> <p>9 Q. So when you say "superficial"</p> <p>10 and -- I'm sorry -- 80 percent of the bladder</p> <p>11 tumors are what you call superficial tumors --</p> <p>12 A. That's correct.</p> <p>13 Q. -- correct? What that means is that</p> <p>14 they are found only in the -- I guess, the</p> <p>15 outermost or innermost tissue of the bladder?</p> <p>16 A. That's correct. They are in the</p> <p>17 most superficial layer of the bladder, that being</p> <p>18 the epithelium, limited by the basement membrane</p> <p>19 below, which is the submucosa.</p> <p>20 Q. If you don't do anything with it,</p> <p>21 and assume it doesn't evade --</p> <p>22 A. Invade.</p> <p>23 Q. -- invade other layers of tissue,</p> <p>24 will it spread in the epithelium?</p> <p>25 A. For the vast majority of these</p>	<p>55</p> <p>1 Was that a bad question?</p> <p>2 A. Yeah.</p> <p>3 Q. Okay.</p> <p>4 A. Can you rephrase that?</p> <p>5 Q. I'm not sure I can, Doctor. In</p> <p>6 other words, I guess, in your mind as a doctor, as</p> <p>7 a treating doctor -- treating physician in the</p> <p>8 context of bladder cancer, you categorize the</p> <p>9 tumors --</p> <p>10 A. Yes.</p> <p>11 Q. -- and one of the reasons you</p> <p>12 categorize is because you know, clinically, that</p> <p>13 some tests are better at finding that type of</p> <p>14 tumor?</p> <p>15 MR. WATTLEWORTH: Object to the</p> <p>16 form.</p> <p>17 BY MR. LEGER:</p> <p>18 Q. Correct?</p> <p>19 A. No.</p> <p>20 Q. Okay.</p> <p>21 A. No. When those tests detect a</p> <p>22 tumor, they don't tell us what grade the tumor is.</p> <p>23 They just detect the presence of the tumor.</p> <p>24 Q. Okay. And by "grade," you mean</p> <p>25 what, Doctor?</p>
<p>56</p> <p>1 tumor, no.</p> <p>2 Q. Okay. So the risk of the</p> <p>3 superficial tumor, though, is that it will spread</p> <p>4 to other layers; correct?</p> <p>5 A. The risk is the potential for</p> <p>6 invasion.</p> <p>7 Q. Okay. Now, invasion -- now, is</p> <p>8 there also a risk of metastasis?</p> <p>9 A. Not from a superficial tumor.</p> <p>10 Q. Okay. Now, once the superficial</p> <p>11 tumor invades other tissue, does it then have a</p> <p>12 potential for metastasis?</p> <p>13 A. That's correct.</p> <p>14 Q. Okay. And at that point, then it's</p> <p>15 no longer a superficial tumor?</p> <p>16 A. That's correct, by definition.</p> <p>17 Q. Now, there are also other bladder</p> <p>18 tumors that, by their nature, are not superficial</p> <p>19 but rather are invasive?</p> <p>20 A. That's correct.</p> <p>21 Q. And that -- and hence the</p> <p>22 distinction that you made earlier between the</p> <p>23 superficial tumor detection by one test over the</p> <p>24 other and the invasive tumor detection potential of</p> <p>25 other procedures; correct?</p>	<p>57</p> <p>1 A. What is -- okay. Grade is a</p> <p>2 pathologic designation based on certain cytologic</p> <p>3 characteristics; that is, these are characteristics</p> <p>4 within the cytoplasm of the cell, or within the</p> <p>5 nucleus of the cell, that are -- have been</p> <p>6 characterized as having degrees of</p> <p>7 dedifferentiation; that is, they don't look like</p> <p>8 the normal parent tissue.</p> <p>9 And the more abnormal they look, the</p> <p>10 higher the grade they are, and we correlate</p> <p>11 that -- we hope this is accurate -- with what</p> <p>12 their potential biological activity might be, and</p> <p>13 so that a higher grade tumor would tend to have a</p> <p>14 more malignant behavior in the future than a lower</p> <p>15 grade tumor.</p> <p>16 Q. Theoretically --</p> <p>17 A. And in general, that's true.</p> <p>18 Q. I'm sorry. Generally, you would</p> <p>19 rather catch, or find and diagnose, the malignant</p> <p>20 tumor at a lower number grade; correct?</p> <p>21 A. That's correct.</p> <p>22 Q. If you have your preference --</p> <p>23 A. Oh --</p> <p>24 Q. -- as a diagnostician?</p> <p>25 A. That's correct.</p>

<p>58</p> <p>1 Q. You would rather find it at T-1 -</p> <p>2 A. That's correct.</p> <p>3 Q. - than find it at T-4/5; correct?</p> <p>4 A. That's correct.</p> <p>5 Q. And -</p> <p>6 MR. WATTLEWORTH: Walter, are we</p> <p>7 getting to a point where we might take a break?</p> <p>8 MR. LEGER: We'll take a break,</p> <p>9 yeah.</p> <p>10 (A brief recess is taken.)</p> <p>11 BY MR. LEGER:</p> <p>12 Q. Doctor, we're going to go back to</p> <p>13 this Exhibit A of Cockburn Exhibit No. 1. And we</p> <p>14 had talked about a while back about your billing</p> <p>15 records, and I called for production of those, and</p> <p>16 I realize you don't have them with you. But in</p> <p>17 that regard, when were you first retained in this</p> <p>18 case?</p> <p>19 A. I think in May of this year -</p> <p>20 April.</p> <p>21 Q. And how were you first contacted?</p> <p>22 A. My contact person with the firm with</p> <p>23 whom I had dealt with through the Engle case</p> <p>24 advised me of this pending litigation.</p> <p>25 Q. And who is that?</p>	<p>60</p> <p>1 Monitoring. Have you seen that document? It might</p> <p>2 have been attached to a report of Dr. David Burns.</p> <p>3 A. I think so, yes. It looks familiar.</p> <p>4 Q. And there is specific reference -</p> <p>5 A. Yes.</p> <p>6 Q. - to the medical monitoring</p> <p>7 program. You agree, Doctor, that there's - I'm</p> <p>8 sorry - medical monitoring regarding bladder</p> <p>9 cancer is referred to in that document, as well</p> <p>10 as -</p> <p>11 A. Yes.</p> <p>12 Q. - several other diseases?</p> <p>13 A. Yes, I did see that.</p> <p>14 Q. Now, you also saw that there's a</p> <p>15 little bit more lengthy analysis of the bladder</p> <p>16 cancer issue, particularly in Dr. Sartor's report;</p> <p>17 correct?</p> <p>18 A. Correct.</p> <p>19 Q. Doctor, do you agree that the</p> <p>20 American Cancer Society states that bladder cancer</p> <p>21 screening is not recommended for people without</p> <p>22 symptoms who do not have strong risk factors for</p> <p>23 this disease?</p> <p>24 A. Yes.</p> <p>25 MR. WATTLEWORTH: Object to the</p>
<p>59</p> <p>1 A. Ursula Henninger.</p> <p>2 Q. And what firm is she with?</p> <p>3 A. This one (gestating).</p> <p>4 Q. The firm in North Carolina?</p> <p>5 A. That's correct.</p> <p>6 Q. She called you on the phone?</p> <p>7 A. Correct.</p> <p>8 Q. And what did she tell you about this</p> <p>9 case?</p> <p>10 A. Just the nuts and bolts of it; that</p> <p>11 it was involved with the monitoring of individuals</p> <p>12 who had been exposed to tobacco.</p> <p>13 Q. And what did she ask you to do?</p> <p>14 A. Review the data that she would send</p> <p>15 me, which basically were the reports by, I think,</p> <p>16 Dr. Wiener and Dr. Sartor.</p> <p>17 Q. Okay. Did she eventually also send</p> <p>18 you a copy of what's - what is called the</p> <p>19 monitoring program, a document separate from the</p> <p>20 direct reports of Dr. Wiener and Sartor?</p> <p>21 A. And who is the author of that one?</p> <p>22 Q. Well, it is a group of doctors and</p> <p>23 scholars and medical school people, and I'm going</p> <p>24 to just show you - it's called The Clinical Value</p> <p>25 of Early Detection and Diagnosis and of Medical</p>	<p>61</p> <p>1 form.</p> <p>2 BY MR. LEGER:</p> <p>3 Q. You do agree?</p> <p>4 A. Yes.</p> <p>5 Q. And do you also agree the American</p> <p>6 Cancer Society goes on to state risk factors that</p> <p>7 would justify a screening include proven exposure</p> <p>8 to cancer-causing chemicals, earlier bladder</p> <p>9 cancers, or certain birth defects of the bladder?</p> <p>10 MR. WATTLEWORTH: I'm going to</p> <p>11 object. Just where are you - what are you</p> <p>12 referring to right now? Are you reading out of a</p> <p>13 particular report?</p> <p>14 MR. LEGER: I'm reading out of</p> <p>15 Dr. Sartor's report as quoting the American Cancer</p> <p>16 Society.</p> <p>17 MS. WIMBERLY: And, Walter, are you</p> <p>18 asking if he agrees -</p> <p>19 MR. LEGER: If he agrees that's what</p> <p>20 it says.</p> <p>21 MS. WIMBERLY: - that's what it</p> <p>22 says?</p> <p>23 MR. LEGER: That's right.</p> <p>24 MR. WATTLEWORTH: That's what his</p> <p>25 report says?</p>



<p>62</p> <p>1 MR. LEGER: That's what the report 2 says. 3 MR. WATTLEWORTH: Right. That's 4 your question, if he -- 5 MR. LEGER: And I'm asking -- 6 no -- if that's what the -- if he agrees that's 7 what the American Cancer Society says. 8 THE DEPONENT: You know, the 9 American Cancer Society says so, but in their 10 cancer magazine, they say -- the CA, the cancer 11 magazine of the American Cancer Society -- they say 12 nothing about bladder cancer monitoring. 13 BY MR. LEGER: 14 Q. Okay. And where do they not say -- 15 I'm sorry -- tell me, again, the name of -- 16 A. The CA cancer journal for cancer 17 detection really has no data on there about bladder 18 cancer. 19 Q. Okay. Are you talking about on the 20 Internet or are you talking about the volumes or 21 the magazine that you get -- 22 A. The magazine itself. 23 Q. -- periodically? 24 A. Yeah. 25 Q. Okay. Have you researched it to</p>	<p>64</p> <p>1 A. Well, I agree that people with risk 2 factors and symptoms should be evaluated for 3 bladder cancer, yes. 4 Q. All right. How about people with no 5 symptoms but strong risk factors? Do you think 6 they should be monitored? 7 A. And when you say "monitored," you 8 mean -- 9 Q. I mean, well, screened. 10 A. And that screening would be? 11 Q. In any way. I'm talking about any 12 type of screening. 13 MR. WATTLEWORTH: For any disease? 14 MR. LEGER: No, for bladder cancer. 15 A. Yes, I think, and that screening is 16 the urinalysis. 17 BY MR. LEGER: 18 Q. Okay. And you would agree that -- 19 or would you agree that risk factors that would 20 justify a screening would include proven exposure 21 to cancer-causing chemicals? 22 A. And when you say that "screening," 23 are you talking about the average individual who 24 walks into the doctor's office who says, Yes, I 25 work in an aniline dye factory, or, I work for the</p>
<p>63</p> <p>1 determine if there's -- 2 A. Only to look through the ACS Web 3 site. 4 Q. And you particularly looked for a 5 specific reference to bladder cancer -- 6 A. Yes. 7 Q. -- correct? Do you recall what 8 search criteria you used or search parameters you 9 used? 10 MR. WATTLEWORTH: In looking through 11 the American Cancer Society Web site? 12 MR. LEGER: Web site, yeah. 13 A. No, just cancer detection. 14 BY MR. LEGER: 15 Q. Would you disagree with the 16 suggestion that bladder cancer should not be 17 screened in people with symptoms who do not have 18 strong risk factors? 19 MR. WATTLEWORTH: Object to the 20 form? 21 A. Do I disagree that people should not 22 be -- 23 BY MR. LEGER: 24 Q. Do you agree or disagree with that 25 statement?</p>	<p>65</p> <p>1 petroleum industry in distillation, or -- those 2 individuals or those individuals walking into a 3 general physician's office should be screened per 4 se? 5 Q. Let's talk about those, then -- 6 A. Yeah, I figure -- 7 Q. -- if that's what you would like to 8 do. 9 A. -- they should definitely have a 10 urinalysis. 11 Q. Okay. Why should people who work in 12 the aniline dye industry be screened? 13 A. It just has a higher association of 14 bladder cancer in those individuals who are exposed 15 to aniline dyes. 16 Q. What is the level of association, if 17 you know? 18 A. That there's a risk associated, 19 higher than normal. 20 Q. All right. What is the known 21 association in the context of persons who work in 22 the petroleum industry? 23 A. Again, only a higher association. 24 Q. Okay. And you would advocate 25 screening in those cases, also; is that correct?</p>

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1 A. Yes.  
2 Q. Okay. Would you also advocate  
3 screening for bladder cancer in the case of persons  
4 who have long-term exposure to cigarette smoke?

5 MR. WATTLEWORTH: Object to the  
6 form.

7 A. I want to just make a qualification  
8 here. When someone walks into a doctor's office,  
9 and they're coming asymptotically for a general  
10 medical evaluation, they're going to get a screen,  
11 if that's the word you want to use.

12 BY MR. LEGER:

13 Q. Right.

14 A. They're going to be screened by a  
15 urinalysis.

16 Q. Right.

17 A. Now, if the doctor, in the context  
18 of that screen, finds hematuria, he's going to be  
19 concerned because of the presence of hematuria,  
20 and, yes, his anxiety may be heightened by the  
21 occupational or whatever social exposure to known  
22 carcinogen entities, yes, but that's -- and all  
23 that means is that he might, with greater alacrity,  
24 send him to a urologist for evaluation.

25 Q. Okay. My question is, for example,

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1 in the case of a person who -- or a group of  
2 people, for example, that work in a particular  
3 aniline dye manufacturing facility --

4 A. Mmm-hmm.

5 Q. -- would you recommend that that  
6 group of people be screened, outside of a normal  
7 annual physical checkup, for bladder cancer?

8 A. One has to say, in general, of  
9 course, of course, but how long is the exposure?  
10 How great is the exposure? These are all variables  
11 that have to be brought into the --

12 Q. Okay. You wouldn't oppose screening  
13 people who work in an aniline dye manufacturing  
14 facility being screened; correct?

15 A. I wouldn't, but the secretary on the  
16 fifth floor is not necessarily exposed to the dyes.

17 Q. Okay. So would it be your opinion  
18 that if there is an established or known exposure  
19 to a cancer-causing chemical, that you would not  
20 oppose recommendations of screening for that person  
21 or groups of people similarly situated?

22 MR. WATTLEWORTH: Object to form.

23 A. If the screening is just a  
24 urinalysis, I have no problem with that.

25 BY MR. LEGER:

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1 Q. Now, would you also -- in the  
2 context of setting up a program, for example, of a  
3 group of workers that are directly in contact with  
4 the aniline dye chemical in an aniline dye  
5 manufacturing facility, and we're talking about,  
6 now, constructing a program, would you agree  
7 that -- you've already indicated that you would  
8 agree a urinalysis would be a good  
9 recommendation --

10 A. That's correct.

11 Q. -- in terms of screening. Now, once  
12 urinalysis is performed, if urinalysis is negative  
13 for blood --

14 A. Right.

15 Q. -- for hematuria, then you would  
16 recommend no further screening or monitoring for  
17 bladder cancer; correct?

18 A. That's correct.

19 Q. Now, assuming, in such a program, a  
20 finding positive for hematuria, would you then  
21 recommend further diagnostic testing?

22 A. For him or anyone else; that's  
23 correct.

24 Q. Okay. And you would not be opposed  
25 in that instance to the use of NMP-22 or cytology;

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1 correct?

2 A. Not at all.

3 Q. Okay. Have you provided any written  
4 materials -- and, again, we're back to Exhibit  
5 No. 1 -- any written materials, documents,  
6 writings, or other objects to counsel for  
7 R.J. Reynolds or other tobacco companies in  
8 connection with your expert testimony in this case?

9 A. Not beyond what you have a copy of.

10 Q. Now, in connection with this -- with  
11 your report --

12 MS. WIMBERLY: I don't think you've  
13 identified the report --

14 MR. LEGER: Oh, okay.

15 MS. WIMBERLY: -- as an exhibit yet,  
16 Walter.

17 MR. LEGER: Might as well identify  
18 it, just for the sake of -- because I put all those  
19 numbers on those little tags. Might as well use  
20 them.

21 MR. WATTLEWORTH: Yeah, I think you  
22 just have to identify the reliance list.

23 MS. DESUE: And the CV.

24 MR. WATTLEWORTH: Yeah.

25 MR. LEGER: Oh, I'm sorry. This is

<p>70</p> <p>1 probably your copy that I just pulled off the 2 table.</p> <p>3 MR. WATTLEWORTH: I believe it is.</p> <p>4 MR. LEGER: Is that because you -- 5 you got a tag across the top, so --</p> <p>6 MR. WATTLEWORTH: Yeah, yeah, that's 7 mine. Do we have another copy of it anywhere? I 8 mean --</p> <p>9 MS. DESUE: Let me see if I've got 10 another copy.</p> <p>11 MR. WATTLEWORTH: -- we can make a 12 copy of it. That's okay.</p> <p>13 MR. LEGER: I'm sorry. I don't --</p> <p>14 MS. DESUE: I don't have a blank 15 copy. I stupidly wrote on mine, but I have one.</p> <p>16 MR. LEGER: I object to your 17 characterization as your writing --</p> <p>18 MS. DESUE: Being stupid.</p> <p>19 MR. LEGER: -- being stupid, yeah. 20 And I know you really didn't mean it, for the 21 record, Chris.</p> <p>22 MS. DESUE: No, I didn't really.</p> <p>23 BY MR. LEGER: 24 Q. In any event, we're going to attach 25 a copy of that report, Doctor, and I assume -- and</p>	<p>72</p> <p>1 Q. Did he make any changes?</p> <p>2 A. Yes. We made some typographical 3 changes and asked me to clarify my feelings about 4 the -- specifically about the screening evaluation 5 for which individuals in particular.</p> <p>6 Q. What part of that -- of your report 7 would that be? The --</p> <p>8 A. Fourth --</p> <p>9 Q. -- fourth paragraph?</p> <p>10 A. -- paragraph down.</p> <p>11 Q. So he suggested that you add on that 12 last sentence; is that correct?</p> <p>13 MR. WATTLEWORTH: Hold on a second. 14 Let me see -- take a look at this.</p> <p>15 A. In the context of, did I know of 16 any --</p> <p>17 BY MR. LEGER: 18 Q. Right.</p> <p>19 A. -- recommended cancer screening --</p> <p>20 MR. WATTLEWORTH: Wait. I'm --</p> <p>21 A. -- specifically for smokers, no.</p> <p>22 MR. WATTLEWORTH: Okay. Just so I'm 23 clear, since I didn't have this report in front of 24 me when you asked that question -- 1, 2, 3 -- 25 fourth paragraph, you're saying -- your question</p>
<p>71</p> <p>1 mine is marked, also, but I'm talking about this 2 report --</p> <p>3 A. Correct.</p> <p>4 Q. -- correct?</p> <p>5 MR. WATTLEWORTH: And you're free to 6 use mine to refer to for now --</p> <p>7 MR. LEGER: Okay. Yeah, if you 8 would.</p> <p>9 MR. WATTLEWORTH: -- if you want, if 10 it'll speed things along.</p> <p>11 MR. LEGER: Thank you.</p> <p>12 MS. WIMBERLY: And, Walter, that's 13 going to be Exhibit 4?</p> <p>14 MR. LEGER: That will be Exhibit 15 No. 4 we're identifying -- marked for 16 identification as Cockburn No. 4.</p> <p>17 BY MR. LEGER: 18 Q. Doctor, was that report typed in 19 your office?</p> <p>20 A. Yes, it was.</p> <p>21 Q. Okay. Was -- before a final draft 22 was prepared, was it sent to anyone for review?</p> <p>23 A. Yes, it was.</p> <p>24 Q. Who was it sent to?</p> <p>25 A. Mr. Wattleworth.</p>	<p>73</p> <p>1 was, did I suggest that he add that last sentence 2 on there? Is that what your question is?</p> <p>3 MR. LEGER: Yeah. I'm not asking 4 you, though.</p> <p>5 MR. WATTLEWORTH: I know you're not, 6 but I didn't have the report, so -- and he said -- 7 okay. And his answer was no. Okay.</p> <p>8 MR. LEGER: Well, I'm not sure that 9 was his answer.</p> <p>10 MR. WATTLEWORTH: The problem is, 11 now that I've given you my report, I don't have a 12 copy to look at.</p> <p>13 MR. LEGER: I'm sorry. Take all the 14 time you need, Counsel, before you answer that 15 question.</p> <p>16 MR. WATTLEWORTH: Go ahead.</p> <p>17 BY MR. LEGER: 18 Q. No, I'm simply wondering, did he ask 19 you to give the opinion on that subject matter? 20 I'm not trying to play games.</p> <p>21 A. Yeah, I know. He asked me my 22 opinion on that, do I know --</p> <p>23 Q. Lawyers do that, and I'm not even 24 saying there's anything wrong with that. I'm just 25 wondering --</p>

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1 A. Okay.  
2 Q. -- if he asked you to add that -- an  
3 opinion on that subject.  
4 A. He asked for my opinion on that  
5 subject, yes.  
6 Q. Okay. And your opinion, as it  
7 states, is that you're not aware of a medical  
8 association which advocates bladder cancer  
9 screening for smokers who are asymptomatic or  
10 without hematuria --  
11 A. Correct.  
12 Q. -- correct? And you've already  
13 given the opinion that you have no problem with  
14 those exposed to environmental cancer-causing  
15 agents being screened if they have hematuria;  
16 correct?  
17 A. That's correct.  
18 Q. Okay. Are you aware of any major  
19 medical associations which advocate against bladder  
20 cancer screening for smokers, period?  
21 A. No.  
22 Q. Or question that, rather. Are you  
23 aware of any major medical association which  
24 advocates against bladder cancer screening for  
25 smokers with hematuria?

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1 A. No.  
2 Q. Now, you are aware that there are  
3 groups or organizations that advocate against  
4 cystoscopy as a method of screening, correct?  
5 MR. WATTLEWORTH: Object to the  
6 form.  
7 A. Screening for whom?  
8 BY MR. LEGER:  
9 Q. Screening for bladder cancer.  
10 A. In patients who are --  
11 Q. In an asymptomatic patient.  
12 A. Without hematuria?  
13 Q. Yes, sir.  
14 A. I'm also against that.  
15 Q. Okay. And why?  
16 A. What's the need?  
17 Q. Okay. The -- okay. My next  
18 question is, would you also oppose the use of  
19 cystoscopy in screening in a person exposed to  
20 environmental carcinogens who have no symptoms?  
21 A. And when you say -- again, is that  
22 using cystoscopy for that screening?  
23 Q. Yes.  
24 A. Without hematuria, there is very  
25 little indication for doing a cystoscopy, so I am

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1 opposed; correct.  
2 Q. You would agree, generally, that  
3 cystoscopy is not a recommended form of screening,  
4 period; correct?  
5 MR. WATTLEWORTH: Object to the  
6 form.  
7 A. See, we're --  
8 BY MR. LEGER:  
9 Q. Yes.  
10 A. -- skipping around the word  
11 "screening" here --  
12 Q. Yes. Okay.  
13 A. -- and, again, I believe that the  
14 urinalysis is the screening test.  
15 Q. Okay.  
16 A. Okay? You are guilty until proven  
17 otherwise if you have blood in your urine, and  
18 it's --  
19 Q. Right.  
20 A. -- my responsibility to find the  
21 tumor, so yes.  
22 Q. That's the threshold primary  
23 screen --  
24 A. That's correct.  
25 Q. -- correct -- urinalysis?

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1 A. That's correct.  
2 Q. And then you work your way down the  
3 ladder and you continue to screen --  
4 A. That's correct.  
5 Q. -- and with different tests and  
6 different procedures, and at some point, even, a  
7 cystoscopy can be both a screen and/or a diagnostic  
8 tool; correct?  
9 A. When you say "screen," it is  
10 diagnostic. It is -- I don't think of it as  
11 screening.  
12 Q. Okay.  
13 A. At that point, that person is -- has  
14 something that I have to find the reason for --  
15 Q. Okay.  
16 A. -- so it's no longer a screen.  
17 Q. And, in fact, cystoscopy is  
18 invasive; correct?  
19 A. That's correct.  
20 Q. And it's quite expensive, relative  
21 to other forms of screen, like urinalysis; correct?  
22 MR. WATTLEWORTH: Object to the  
23 form.  
24 A. I don't know what the cost of an  
25 NMP-22 is, but I think cystoscopy costs as much as

<p>78</p> <p>1 a cytology does.</p> <p>2 BY MR. LEGER:</p> <p>3 Q. Okay. How much does --</p> <p>4 A. Cytology?</p> <p>5 Q. -- cystoscopy --</p> <p>6 A. Cystoscopy?</p> <p>7 Q. -- cost? Forgive me -- I'm really</p> <p>8 having trouble with this word, and I've been</p> <p>9 practicing, Doctor.</p> <p>10 A. Sure. "Cyst-o-scope-y".</p> <p>11 Q. "Cyst" --</p> <p>12 A. "Cysto" is for bladder --</p> <p>13 Q. -- "o-scope-y."</p> <p>14 A. -- and "scopy" is to look. Now I</p> <p>15 forgot the question.</p> <p>16 Q. So did I, Doctor. The cost --</p> <p>17 A. Oh, oh.</p> <p>18 Q. -- of cystoscopy.</p> <p>19 A. I think Medicare pays about \$120 for</p> <p>20 it.</p> <p>21 Q. How long does it take?</p> <p>22 A. Less than ten minutes.</p> <p>23 Q. Generally outpatient?</p> <p>24 A. Almost always.</p> <p>25 Q. And you have no materials, no</p>	<p>80</p> <p>1 A. Mailed.</p> <p>2 Q. Or fax or otherwise?</p> <p>3 A. Faxed and then mailed.</p> <p>4 Q. Okay. Do you keep copies of your</p> <p>5 fax receipts and that type of thing?</p> <p>6 A. No.</p> <p>7 Q. Have you made any speeches or public</p> <p>8 statements or participated in any lectures in</p> <p>9 connection with bladder cancer?</p> <p>10 A. Yes.</p> <p>11 Q. Where and when?</p> <p>12 A. The last one was in February of this</p> <p>13 year in a forum sponsored by a drug company for a</p> <p>14 health fair for African-American males.</p> <p>15 Q. And you spoke about bladder cancer?</p> <p>16 A. (Deponent nods head.)</p> <p>17 Q. Was that --</p> <p>18 A. Bladder and prostate cancer.</p> <p>19 Q. Did you prepare a paper?</p> <p>20 A. I had notes, but I didn't -- I spoke</p> <p>21 extemporaneously.</p> <p>22 Q. Okay. Did you keep your notes?</p> <p>23 A. No.</p> <p>24 Q. What was the general gist of the</p> <p>25 discussion?</p>
<p>79</p> <p>1 documents whatsoever, directly related to either</p> <p>2 Ms. Jackson or Ms. Scott?</p> <p>3 A. No, sir.</p> <p>4 Q. Do you have any correspondence with</p> <p>5 the lawyers for Reynolds or other tobacco</p> <p>6 companies, including but not limited to, electronic</p> <p>7 mail?</p> <p>8 A. No.</p> <p>9 Q. You did not communicate by Internet?</p> <p>10 A. No.</p> <p>11 Q. They send you any letters other than</p> <p>12 enclosure-type letters?</p> <p>13 A. None.</p> <p>14 Q. Did they send you enclosure letters?</p> <p>15 A. Enclosure letters, yes.</p> <p>16 Q. Enclosed is a copy of?</p> <p>17 A. Correct.</p> <p>18 Q. Did you send them any, enclosed is a</p> <p>19 copy of?</p> <p>20 A. No, other than the report.</p> <p>21 Q. Did the report have an enclosure</p> <p>22 letter with it or did you just send it to them?</p> <p>23 A. No, I just sent it.</p> <p>24 Q. You mailed it to them or sent it by</p> <p>25 Internet?</p>	<p>81</p> <p>1 A. How we contribute to our health or</p> <p>2 unhealth; basically, just diet, nutrition,</p> <p>3 exercise, da-da-da-da-da-da.</p> <p>4 Q. Did you talk about smoking?</p> <p>5 A. Of course.</p> <p>6 Q. Did you point out that smoking is a</p> <p>7 high risk factor in both prostate and bladder</p> <p>8 cancer?</p> <p>9 MR. WATTLEWORTH: Object to the</p> <p>10 form.</p> <p>11 A. I mentioned that it is a risk</p> <p>12 factor, but far more so for heart disease and</p> <p>13 impotence, which concerns most men.</p> <p>14 BY MR. LEGER:</p> <p>15 Q. Is smoking a factor in impotence?</p> <p>16 A. Yes, sir.</p> <p>17 Q. A major factor?</p> <p>18 A. A contributing factor.</p> <p>19 Q. What's the etiology of that? You're</p> <p>20 right; it is of interest.</p> <p>21 A. Only in that studies have shown that</p> <p>22 there's an accelerated arteriosclerotic component</p> <p>23 to heart disease in smokers, and that is the bottom</p> <p>24 baseline of heart disease.</p> <p>25 Q. Did you talk about smoking being a</p>

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1 major risk factor in connection with lung cancer?  
2 MR. WATTLEWORTH: Object to the  
3 form.

4 A. No.

5 BY MR. LEGER:

6 Q. What are the known and  
7 scientifically accepted risk factors in connection  
8 with bladder cancer?

9 A. You're talking about environmental  
10 and industrial exposure?

11 Q. I'm talking about whatever risk  
12 factors the medical community and scientific  
13 community consider.

14 A. Well, the most common cause of  
15 bladder cancer in the world is schistosomiasis.

16 Q. Which is what?

17 A. Which is an infection with the  
18 schistosoma larvae, which then enters your vascular  
19 system and then ends up with the larvae in your  
20 bladder. That causes chronic inflammation and,  
21 eventually, development of squamous cell carcinoma  
22 of the bladder.

23 Q. Okay. How about in the United  
24 States?

25 A. In the United States, there's a very

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1 A. That's correct.

2 Q. In your deposition in the Engles  
3 case, you indicated that you had relied upon about  
4 40 or 50 documents or articles or journals in  
5 connection with the opinions you gave in that case;  
6 is that correct?

7 A. That's correct.

8 Q. Did you rely upon those in the  
9 context of the opinions you've given in this case  
10 as well?

11 A. Not to have specifically reviewed  
12 them, but the general knowledge that I got from  
13 them.

14 Q. What did the -- what was the subject  
15 matter, generally, of that group of articles? I  
16 assume it was somewhat different than the subject  
17 matter of these.

18 A. Well, there's a problem defining  
19 what is carcinogenic and what is not, relative to  
20 bladder cancer, and the multiple sources of  
21 carcinogens in the environment that contribute to  
22 the development of cancer and the incidence of  
23 cancer in certain individuals in certain parts of  
24 the country --

25 Q. Mm-hmm.

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1 high association of bladder cancer in areas in  
2 which there is a major industrial petroleum  
3 industry with distillation and refineries. New  
4 Jersey, Louisiana have high incidence of bladder  
5 cancer in that association.

6 The aniline dye industry has always  
7 been known to be involved with it. Smoking, we  
8 know, has a higher incidence of bladder cancer in  
9 individuals who smoke heavily over a long period of  
10 time. Just about anything that has to do with  
11 hydrocarbons -- people who are involved, let's say,  
12 in motor pools of truck companies, bus companies,  
13 even taxi drivers -- have a higher incidence of  
14 bladder cancer.

15 Q. What -- by the way, what is aniline  
16 dye?

17 A. Aniline is a -- hmm. It's a  
18 component of dyes.

19 Q. Of all dyes, generally, or most  
20 dyes?

21 A. No, most dyes.

22 Q. And aniline is the chemical in the  
23 dye that --

24 A. That's correct.

25 Q. -- is believed to be carcinogenic?

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1 A. -- and the complexity of it all,  
2 such that we don't still know what is the actual  
3 causative factor of bladder cancer relative to,  
4 say, smoking.

5 Q. Okay. So may I understand what  
6 you're saying is that in the Engle case, the issue  
7 that you dealt with was whether or not smoking  
8 causes bladder cancer?

9 A. That's correct.

10 Q. And your opinion was that there  
11 isn't sufficient scientific data to establish  
12 smoking as the cause of bladder cancer; correct?

13 A. That's correct.

14 Q. But you also agreed that smoking is  
15 a known cause of bladder cancer --

16 A. Definitely.

17 Q. -- correct? And you also agreed in  
18 that case that cigarette smoking significantly  
19 increases the risk in a person to bladder cancer  
20 over that of a normal -- over that of a nonsmoker;  
21 correct?

22 MR. WATTLEWORTH: Object to the  
23 form.

24 A. With the only modification of the  
25 amount of smoking and the duration of smoking.

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1 BY MR. LEGER:

2 Q. The — is it your testimony that the  
3 scientific data suggests that the incidence of  
4 bladder cancer in smokers is relative to duration  
5 of smoking and the amount of cigarettes they smoke?

6 A. Correct.

7 Q. So there is a dose response,  
8 effectively —

9 A. That's correct.

10 Q. — correct? And that's true of many  
11 carcinogens in the context of causation and cancer;  
12 correct?

13 A. That's correct.

14 Q. In fact, that's one of the principal  
15 characteristics of a carcinogen; correct? The  
16 chance of developing cancer is related to dose and  
17 response?

18 A. That's correct.

19 Q. Doctor, I'm going to refer you to  
20 your curriculum vitae at this time — you probably  
21 don't need to look at it, but I do — and just ask  
22 you a few questions there. You have some  
23 special training in urological oncology;  
24 correct?

25 A. Yes.

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1 A. Well, yes, you could call cystoscopy  
2 surgery, but it's — I don't consider it surgery  
3 unless I cut something —

4 Q. Okay.

5 A. — in the course of cystoscopy. If  
6 you have a bladder tumor, I'll — I can remove it  
7 through the cystoscope, and that is a surgical  
8 procedure. The actual —

9 Q. Is that called a cystectomy —

10 A. No.

11 Q. — or is that different?

12 A. Cystectomy means removing the whole  
13 bladder.

14 Q. Ah, okay.

15 A. Okay? Here would just be a tumor  
16 resection. It would be cystoscopy with tumor  
17 resection.

18 Q. Okay.

19 A. And then that has to be performed  
20 under anesthesia — general anesthesia.

21 Q. Okay. And are those the forms of  
22 surgery that you do today?

23 A. Yes. I am — or if the patient were  
24 to have invasive bladder cancer, he would have to  
25 have his bladder removed, and then make him a new

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1 Q. And would you tell me about that  
2 training?

3 A. It's a clinical fellowship I did at  
4 the Memorial Sloan Kettering Hospital in New York  
5 from 1980 to 1981 in which my clinical research  
6 actually was looking for bladder tumor antigens in  
7 the urine and — but that was the laboratory  
8 research. My clinical was — basically was surgery  
9 of the bladder, kidney, prostate.

10 Q. What does that mean, your clinical  
11 was surgery? You actually performed surgery?

12 A. I did the surgery, yes.

13 Q. Do you do surgery now?

14 A. Oh, yes.

15 Q. Now, by surgery, you include — in  
16 the definition of surgery, we often think — we lay  
17 people think of surgery as cutting with a knife.

18 A. That's correct.

19 Q. But there's also other forms of  
20 surgery —

21 A. Right.

22 Q. — like cystoscopy?

23 A. Right.

24 Q. That is what you call surgery. And  
25 what else? What other types of surgery do you do?

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1 bladder out of his colon. That's part of my  
2 surgery, too.

3 Q. And you do that type of surgery,  
4 also.

5 In the context of your curriculum  
6 vitae, at Columbia you were an assistant professor  
7 of urology. What does that mean?

8 A. Well, it's a step above —

9 Q. What's an assistant professor?

10 A. — a step above instructor and one  
11 below associate professor.

12 Q. Okay. I mean, did you teach  
13 classes?

14 A. No. In that context, a clinician or  
15 an academician is teaching medical students in the  
16 hospital, not in a didactic setting in a classroom  
17 per se.

18 Q. Mm-hmm.

19 A. You teach them on rounds, you teach  
20 them in the operating room — in that way.

21 Q. So while in that capacity, you were  
22 basically an employee of the hospital or the  
23 medical school?

24 A. Yes.

25 Q. And not in private practice?

1 A. That's correct.

2 Q. Okay. Now, since 1985, you've been  
3 at the University of Florida in Tampa; correct?

4 A. South Florida, yes.

5 Q. I'm sorry. South Florida in Tampa.  
6 And -- but you have also been in private practice;  
7 is that right?

8 A. Right. So my association with the  
9 university is a clinical appointment, and that  
10 means I don't get paid but I do pretty much the  
11 same thing in terms of teaching residents.

12 Q. So you don't stand up in front of a  
13 classroom of med students and lecture them --

14 A. No.

15 Q. -- with a blackboard and that kind  
16 of thing?

17 A. No.

18 Q. And so do I understand that  
19 basically you have privileges at the University of  
20 South Florida Medical Center or some facility?

21 A. Tampa General Hospital, which is  
22 their main teaching hospital, yes.

23 Q. I mean, is there an actual  
24 University of South Florida medical school?

25 A. No.

1 A. No. When you have "clinical" in  
2 front of it, you're not being paid.

3 Q. Okay. And so you go from professor,  
4 assistant professor, associate professor, and then  
5 clinical assistant professor; correct? That's --

6 A. You can be a clinical associate or  
7 clinical professor, too.

8 Q. Okay. That's enough for me. It's  
9 getting beyond my mental capacity to understand.

10 The Tampa General Hospital, I  
11 assume, is not the only hospital at which you have  
12 privileges today --

13 A. That's correct.

14 Q. -- correct? And those privileges  
15 are listed under --

16 A. Yes.

17 Q. -- hospital affiliations? Now, I'm  
18 also -- I'm looking at unpublished presentations at  
19 major medical meetings, and you list -- 1, 2 --  
20 three. Do any of them have to do with bladder  
21 cancer?

22 A. No.

23 Q. Any of them have to do with cancer  
24 at all? If you want to --

25 A. Yes, all were involved with

1 Q. Okay. Are there any professors of  
2 urology at the University of South Florida?

3 A. Yes.

4 Q. Are they paid, also -- are they  
5 paid?

6 A. They are paid.

7 Q. Okay. A clinical assistant  
8 professor is not, correct?

9 A. Correct.

10 Q. Would an assistant professor be  
11 paid?

12 A. Yes.

13 Q. And there are --

14 A. Yes.

15 Q. -- assistant professors?

16 A. Yes.

17 Q. And those people, either a professor  
18 or an assistant professor, do not have private  
19 practices?

20 A. Correct.

21 Q. Okay. And the next step --  
22 professor or assistant professor -- is there an  
23 associate professor?

24 A. Yes.

25 Q. And is that person paid?

1 cancers. The first one was the germ cell tumors of  
2 the testicle, the second was treatment of prostatic  
3 carcinoma, and the third one was also germ cell  
4 tumors of the testicle.

5 Q. None of these articles had anything  
6 to do with medical screening or diagnosis in  
7 relation to bladder cancer; correct?

8 A. That's correct.

9 Q. None of them had to do with the  
10 analysis of -- or principles of screening, or  
11 particularly the tools of screening or otherwise --

12 A. No.

13 Q. -- correct? And in the context of  
14 your publications, may I assume that the last  
15 publication you were involved in was 1984?

16 A. That's correct.

17 Q. And none of those publications had  
18 to do with bladder cancers, except for perhaps  
19 No. 6?

20 A. That's correct.

21 Q. And that was in 1984?

22 A. That's correct.

23 Q. Was there any analysis in that  
24 article of predicting tools?

25 A. No. They weren't available at that



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1 time.

2 Q. So these tests that we talked about  
3 and that you talked about, really, in your  
4 report — NMP-22, BTA Stat, FDP, Telomerase assay,  
5 and others — and the search for markers in P 53  
6 gene, etc. — are relatively new developments, in  
7 the '90s, perhaps?

8 A. That's correct.

9 Q. Particularly, the latter part of the  
10 '90s, correct?

11 A. That's correct.

12 Q. Do you particularly have any opinion  
13 as to whether or not there are currently very  
14 promising emerging technologies in the context of  
15 laboratory tests to predict and find bladder tumor?

16 A. Beyond those that were mentioned  
17 here?

18 Q. Yes, sir.

19 A. Oh, I'm certain that there are. I  
20 know that there are. Now that the human genome  
21 project has been completed, there are a number of  
22 different probes that are being exploited to look  
23 into what really is cancer, how cancer starts from  
24 the beginning, what are the signals that turn them  
25 on; and then as we learn more about the signals,

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1 for the hospital in three months so that you do  
2 your cystoscopy under anesthesia because you may be  
3 resecting a tumor at that time. That way, you  
4 obviate the need for doing it twice.

5 Q. Okay. And the importance, then, of  
6 the other diagnostic tools, the laboratory tools,  
7 are to, prior to that scheduling in the hospital in  
8 six months, be able to monitor progress, etc.; is  
9 that correct?

10 A. That's correct.

11 Q. Now, other than the deletion of  
12 manuscript in preparation on your curriculum vitae,  
13 no other significant changes that we ought to be  
14 aware of; correct?

15 A. No, other than the change of the  
16 name of the hospital on page 2 on the bottom from  
17 Centurian Hospital is now University Community  
18 Hospital. Same hospital, different name.

19 Q. Okay. An attending urologist just  
20 means that you're a urologist in private practice  
21 that has privileges at the hospital?

22 A. Privileges to practice at the  
23 hospital; correct.

24 Q. Now, by "private practice," I assume  
25 that means you have a private office that has your

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1 where we can modulate them or — and gain further  
2 insight into what we want to know, mostly not so  
3 much as whether or not there is a cancer there as  
4 what is the malignant potential of that cancer in  
5 particular; how scrupulously do we have to monitor  
6 that patient?

7 Q. And by "scrupulously," you mean how  
8 closely you should monitor for fear of growth of —

9 A. No.

10 Q. — spreading —

11 A. We have to do cystoscopy on every  
12 single one of them every three months. We're  
13 trying to reduce the number of cystoscopies that we  
14 have to do, for all of the reasons you mentioned  
15 before.

16 Q. What you would prefer to do in a  
17 patient with a high risk of bladder cancer or a  
18 malignant tumor is to monitor in some way by  
19 laboratory test as opposed to continue to do  
20 periodic cystoscopies; right?

21 A. Yes and no, but, you see, you still  
22 have to do the cystoscopy. If the tumor marker  
23 comes back positive, what you might do is, instead  
24 of saying, Listen, I'm going to — I want to see  
25 you in my office in three months, you schedule them

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1 name on it —

2 A. That's correct.

3 Q. — the offices of Dr. Cockburn?

4 A. Correct.

5 Q. Do you have any particular  
6 checklists or forms that you have patients  
7 themselves prepare in context of history or  
8 otherwise —

9 A. Yes, I do.

10 Q. — when they come to your office?

11 Can we — we asked for that — I believe we  
12 did — and I believe that's what this is in here,  
13 and I was wondering if we can get a copy of those.

14 A. You certainly can.

15 MS. WIMBERLY: Walter, which part of  
16 the subpoena are you referring to?

17 MR. LEGER: That would be No. 25 —  
18 well, I'm sorry. No, it's not No. 25. It's  
19 No. 24 — no, no, I take that back. Let me look at  
20 it.

21 MS. DESUE: I think it's — keep  
22 going.

23 MR. LEGER: Yeah, it's No. 28. And  
24 actually what I'm looking for is 28, 29,  
25 ultimately, and I'm going to ask about that.

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1 MR. WATTLEWORTH: So right now  
2 you're wanting the history? You're asking for the  
3 history?

4 MR. LEGER: Actually, I want  
5 everything we asked for.

6 MR. WATTLEWORTH: Yeah.

7 MR. LEGER: But I'm asking  
8 specifically --

9 MR. WATTLEWORTH: Right now, you're  
10 talking about the history.

11 MR. LEGER: -- just now about what  
12 the patient fills out.

13 MS. WIMBERLY: I think we have given  
14 you everything other than the billing, and then,  
15 quite frankly, this is something that I don't think  
16 any of us had ever focused on in the context of the  
17 subpoenas.

18 MR. LEGER: Okay. Well, except  
19 that -- and I'm not quibbling with you, except that  
20 this subpoena form is a form that you sent to our  
21 witnesses that we just copied. And I don't mean  
22 that you did, Ms. Wimberly, but lawyers for the  
23 tobacco companies sent, I would suggest  
24 obnoxiously, to some of our first witnesses, and we  
25 don't -- we obviously don't mean it obnoxiously.

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1 We just thought that since you guys were interested  
2 in them, we ought to be interested in them, too.

3 MR. WATTLEWORTH: Can we just agree  
4 that --

5 MR. LEGER: And we can strike that  
6 colloquy, if you --

7 MS. WIMBERLY: And I might tell you,  
8 Walter, we haven't seen a single one from any of  
9 plaintiffs' witnesses. I think everybody's  
10 just kind of overlooked that particular item.

11 MR. WATTLEWORTH: I was going to  
12 suggest that perhaps we handle the request on the  
13 subpoena consistently with how we've been handling  
14 them up to this point.

15 MR. LEGER: Well, I would suggest we  
16 not, because there hasn't -- there's been nothing  
17 consistent about it.

18 MR. WATTLEWORTH: I mean, it sounds  
19 like --

20 MR. LEGER: But I think, generally,  
21 we have been trying to -- we've been trying to get  
22 consistent.

23 MR. WATTLEWORTH: Okay. Well,  
24 we'll --

25 MR. LEGER: And I'm not trying to

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1 start a controversy or even document a controversy  
2 other than just I want to confirm that we -- I  
3 don't think we've had any real firm agreement other  
4 than I thought we agreed to provide everything  
5 three days prior to, and we've been attempting to.

6 MS. WIMBERLY: And our understanding  
7 was simply three days prior we were providing  
8 reliance and attempting to provide prior testimony  
9 and files, but --

10 MR. LEGER: And --

11 MS. WIMBERLY: And certainly this is  
12 something we can get.

13 MR. LEGER: Yeah, right.

14 MS. WIMBERLY: I'm sure it's a  
15 standard form.

16 MR. LEGER: And it's really not that  
17 important in all of them. We've been using these  
18 forms as pertinent.

19 BY MR. LEGER:

20 Q. And I guess, in particular, Doctor,  
21 let me ask you about that. In the form in your  
22 office that the patient is asked to fill out -- and  
23 I assume it's like the typical doctor's -- there's,  
24 like, a clipboard or something, and there's some  
25 form; you sit there and you fill it out yourself?

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1 A. Four pages.

2 Q. Four pages. Is there any question  
3 regarding smoking history?

4 A. Yes.

5 Q. And what does that involve? Does it  
6 just ask, Do you smoke, or --

7 A. Do you smoke and how much and, if  
8 you stopped, how long ago.

9 Q. And is that a form that you  
10 developed yourself?

11 A. Yes.

12 Q. And why is that on the form?

13 A. It's important.

14 Q. Why is it important?

15 A. Well, it's for all the potential  
16 risk problems that have been well documented in the  
17 past, you know, general health, etc.

18 Q. Including, particularly, the risk of  
19 smoking related to bladder cancer, correct?

20 MR. WATTLEWORTH: Object to the  
21 form.

22 A. Not really.

23 BY MR. LEGER:

24 Q. Okay.

25 A. Blood in the urine is such a red

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1 flag to us that -- for so many other things.  
2 Bladder cancer may turn out to be 1 percent of all  
3 the people who do have something positive in their  
4 evaluation for hematuria. So it's not the first  
5 thing on my mind, but as a urologist, it's up  
6 there.

7 Q. It's certainly one of the things you  
8 worry about most, though, isn't it, Doctor?

9 A. Certainly.

10 Q. And certainly one of the things the  
11 patient worries about the most; correct?

12 A. I don't think patients worry about  
13 it enough, no.

14 Q. Okay. Doctor, let me talk to you a  
15 little bit about prostate cancer and the PSA.

16 A. Okay.

17 Q. Does the smoking present a high risk  
18 factor for prostate cancer?

19 A. Not in any epidemiological study  
20 that I've noted.

21 Q. Okay. The -- what is the -- how is  
22 a PSA performed?

23 A. Simply a blood test.

24 Q. And there's laboratory testing to  
25 look for what in the blood?

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1 A. That was suggestive of the need for  
2 a PSA, yes.

3 Q. And what is that?

4 A. That's genetics, whether or not a  
5 blood relative had had prostate cancer.

6 Q. Anything else? Environmental  
7 exposures? Age? Anything else?

8 A. No. Age is almost a truism, because  
9 any man -- the incidence of prostate cancer rises  
10 to almost 70 percent in men over the age of 80, so  
11 it's common.

12 Q. The incidence being that men --  
13 that --

14 A. There's an age-related --

15 Q. -- 70 percent of prostate cancers  
16 are found in men who are over 80?

17 A. No. Put it the other way.

18 Q. That in men over 80, 70 percent of  
19 them have prostate cancer?

20 A. That's correct.

21 Q. How about men over, like, 48?

22 A. One in three. There are four of us  
23 in here.

24 Q. I think only two of us are over 48,  
25 Doctor.

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1 A. Looking for PSA. PSA is prostate  
2 specific antigen. It's an antigen in the blood  
3 that is identifiable by antibody -- antigen complex  
4 techniques.

5 Q. Okay. Is the PSA recommended as a  
6 screening methodology to the general population of  
7 males?

8 A. Only by the American Urological  
9 Association, not by the American Family Practice  
10 Association.

11 Q. Do you know why there is a  
12 recommendation by the urologists but not the family  
13 practice people?

14 A. Well, it's our bailiwick. That's  
15 what we are charged to protect and defend against,  
16 and we see a higher incidence of it, obviously,  
17 because that's our specialty, and so our concerns  
18 are skewed in that direction. Family Practice  
19 Association feels that the incidence of prostate  
20 cancer is not high enough that warrants a general  
21 statement that everyone should have it on the  
22 regularity that has been proposed by the AUA.

23 Q. Okay. Is there a particular risk  
24 factor that would -- in the view of the field of  
25 urologists -- that would be suggestive of a PSA?

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1 A. That's true.

2 MR. WATTLEWORTH: I'll mark it on my  
3 calendar.

4 MR. LEGER: And, for the record, I'm  
5 not admitting that I'm over 39. That's my story,  
6 I'm sticking to it, and I'm not under oath,  
7 Doctor.

8 BY MR. LEGER:

9 Q. As a part of your normal checkup of  
10 a person -- well, strike that.

11 When a person comes to see you, are  
12 they ordinarily referred by another physician for  
13 the first-time visit?

14 A. I'd say 50 percent of my practice is  
15 referral, yes.

16 Q. Where do the other 50 percent come  
17 from? How do they get to you?

18 A. When you say "referred," you mean by  
19 another physician? The other 50 percent come word  
20 of mouth or their own knowledge that a urologist is  
21 indicated for sexual dysfunction, urinary tract  
22 infections, incontinence --

23 Q. I guess that's my question. How  
24 does the ordinary person get to a urologist?

25 A. Yeah.

27 (Pages 102 to 105)

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- 1 Q. Is it the — 50 percent of them, you  
2 said, are generally referred by perhaps a general  
3 practitioner or someone who's treating them for  
4 something else; correct?  
5 A. That's correct.  
6 Q. Or a general practitioner who  
7 observes urological symptoms?  
8 A. That's correct.  
9 Q. The other 50 percent come to you  
10 with some other reason; they even have an idea —  
11 A. Their own sophistication and  
12 knowledge of medicine.  
13 Q. Okay. When you see a patient for  
14 the first time, you take, I assume, a pretty  
15 detailed history?  
16 A. That's correct.  
17 Q. And you — do you perform any  
18 particular tests?  
19 A. Yes.  
20 Q. And I'm talking about a patient that  
21 comes to you not referred for specific testing or a  
22 look by another doctor —  
23 A. Yes.  
24 Q. — correct?  
25 A. Yes.

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- 1 Q. What tests do you perform as a  
2 matter of course?  
3 A. A physical examination, from blood  
4 pressure onward, and depending on the complaint, a  
5 urinalysis for everyone. If someone comes in  
6 complaining of sexual dysfunction, I probably won't  
7 look at his urine.  
8 Q. Okay. Do you do a PSA?  
9 A. If they're over 50 and they — if  
10 they haven't had one in the past year.  
11 Q. And the reason you do a PSA for  
12 males over 50 is that because there is  
13 statistically and epidemiologically shown a very  
14 high risk of prostate cancer?  
15 A. That's correct.  
16 Q. Okay. I'm going to — do you  
17 have — no, you don't have this before you. I'm  
18 just going to go through a number of tests and ask  
19 if you have any association in your ordinary  
20 practice with performing these or reading it.  
21 You certainly don't have any  
22 involvement with doing a needle biopsy of the lung;  
23 correct?  
24 A. No, sir.  
25 Q. Bronchoscopy?

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- 1 A. Nothing above the waist.  
2 Q. Nothing above the waist.  
3 MS. DESUE: That's cute.  
4 BY MR. LEGER:  
5 Q. Nothing to do with the — with  
6 stress testing, any cardiographic testing  
7 whatsoever?  
8 A. I may stress some individuals, but,  
9 no, I don't —  
10 Q. All right. You perform cystoscopy?  
11 A. I do.  
12 Q. Intravenous pyelography?  
13 A. No. I order that. That's a —  
14 Q. Okay.  
15 A. — radiological test.  
16 Q. Okay. But that's something that you  
17 observe and you supervise, and it's pertinent to  
18 your practice?  
19 A. That's correct.  
20 Q. CT scans?  
21 A. No.  
22 Q. What's a VAT wedge? Is that  
23 something in your practice?  
24 A. No.  
25 Q. Okay. I didn't think so. Do you —

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- 1 is testing of the blood for lipids pertinent to  
2 your practice?  
3 A. Not regularly.  
4 MR. LEGER: If you'd like to take a  
5 break, the videotape is near the end and this is a  
6 logical point.  
7 (A brief recess is taken.)  
8 BY MR. LEGER:  
9 Q. Doctor, in the context of your  
10 ordinary office visits with patients, if you  
11 observe a smoking history of a patient, do you talk  
12 to them or counsel them with regard to smoking  
13 itself?  
14 A. I do, depending on the level of  
15 smoking that they admit to.  
16 Q. And what form does that counseling  
17 take?  
18 A. Well, if I see that they smoke  
19 excessively — and to me, excessive is more than,  
20 say, a half a pack a day — then I will counsel  
21 them and explain to them their risks for  
22 cardiovascular disease, lung problems and,  
23 remotely, bladder cancer.  
24 Q. Do you — have you ever had  
25 occasion, in your treatment of individuals, to

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1 refer patients for assistance in cessation of  
2 smoking?  
3 A. Have I referred -- yes, I have.  
4 Q. And tell me about that.  
5 A. When someone smokes excessively and  
6 is having problems from that, then I strongly  
7 suggest that they stop and then recommend one of  
8 the various means that are available to help them  
9 stop, from Zyban to counseling.  
10 Q. Do you prescribe Zyban?  
11 A. No, I don't, because the follow-up  
12 is more complex than I want to be involved with.  
13 Q. I mean, do you get to the point of  
14 recommending particular modalities to assist in  
15 stopping a smoker?  
16 A. I don't -- I feel that I educate  
17 them more than recommend them, and then recommend  
18 them to an internist for smoking cessation.  
19 Q. You don't refer them to a  
20 psychiatrist, do you?  
21 A. No.  
22 Q. You believe that the family care  
23 physician is the primary treator for  
24 smoking-related problems in the context of the  
25 smoking itself?

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1 A. Yes, because I see it as a  
2 mechanical habituation, and I think that drug  
3 therapy works fairly well with it. People -- I  
4 wouldn't send them to a psychiatrist for smoking,  
5 but people who smoke tend to smoke because of  
6 emotional problems that they may have, so from that  
7 standpoint, I will send them, and smoking is just a  
8 symptom of their general pathology.  
9 Q. Do you know that the Surgeon General  
10 has declared that smoking is an addictive activity?  
11 A. Oh, I am sure it is.  
12 Q. And you don't disagree that nicotine  
13 is the addictive agent in cigarettes?  
14 A. I think that the data -- and I'm not  
15 an addictologist -- shows that the act of  
16 smoking -- and whether or not it's specifically  
17 nicotine, I don't know, but -- that the act of  
18 smoking is habit forming and that some form of  
19 addiction can occur.  
20 Q. Are you familiar with the -- would  
21 you agree that it is the Surgeon General's and the  
22 United States Public Health Service definitions and  
23 opinions regarding the addictive nature of nicotine  
24 which are the factors which define the term  
25 "nicotine addiction" as it is commonly used today

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1 in the medical and scientific community?  
2 MR. WATTLEWORTH: Object to the  
3 form.  
4 A. I don't know -- I specifically don't  
5 know where that comes from or if it's attributable  
6 to the Surgeon General. I know that smoking is an  
7 addictive behavior, yes. So is eating.  
8 BY MR. LEGER:  
9 Q. So you believe that smoking is an  
10 addictive behavior like eating?  
11 A. I think that anything that feels  
12 good or gives pleasure is potentially addictive.  
13 Q. Okay. What is your definition of  
14 addictive? Was that it?  
15 A. Mine, I guess, would be a dictionary  
16 definition, and that is a physiological or  
17 psychological dependence on a substance or action  
18 that the individual feels incapable of stopping by  
19 himself.  
20 Q. Okay. Now, you are aware that the  
21 health care community has determined that nicotine  
22 has psychoactive properties; correct?  
23 A. That's correct.  
24 Q. And you would also agree that  
25 nicotine has reinforcing properties; correct?

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1 A. What do you mean by that?  
2 Q. That the -- are you familiar with  
3 the term "reinforcement"?  
4 A. No.  
5 Q. The medical term? Are you an expert  
6 in addiction?  
7 A. By no means.  
8 Q. Are you an expert in the field of  
9 substance dependence?  
10 A. No.  
11 Q. Do you intend to offer opinions  
12 regarding the addictive properties --  
13 A. No.  
14 Q. -- of nicotine at trial in this  
15 case?  
16 A. No, sir.  
17 Q. Have you read the Surgeon General's  
18 reports regarding cigarette smoking?  
19 A. No.  
20 Q. Do you intend to?  
21 A. Excerpts of it.  
22 Q. I'm sorry?  
23 A. Excerpts, I've read, but, no, I  
24 don't plan to read the whole thing.  
25 Q. Have you ever treated persons in

29 (Pages 110 to 113)

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1 your medical practice who have problems with the  
2 use of drugs such as heroin —

3 A. Yes.

4 Q. — cocaine, alcohol?

5 A. Yes.

6 Q. Do heroin or cocaine or alcohol have  
7 any particular significance in the context of your  
8 practice when used by patients?

9 A. Only in a complication of potential  
10 anesthesia.

11 Q. Now, have you — I assume you do no  
12 particular counseling with regard to patients who  
13 use cocaine, alcohol, heroin, or other opiates in  
14 connection with their use of those drugs?

15 A. No.

16 Q. Is there a place on your form or  
17 your checklist when you see a new patient asking  
18 them regarding the use of drugs?

19 A. No — yes, there is one in the  
20 general form asking what drugs they are taking,  
21 but —

22 Q. You don't ask, Are you using  
23 heroin? Are you using cocaine?

24 A. No, I don't.

25 Q. How, in the ordinary course, would

115

1 you — in a typical case — would you come to find  
2 out that a patient is using one of those drugs?

3 A. Either I suspect it and I ask it or  
4 the patient will tell me, I'm a reformed alcoholic  
5 or reformed drug abuser.

6 Q. Have — in the course of your  
7 practice, have you observed physical properties or  
8 characteristics of smokers which suggest that they  
9 are smokers, I mean, in terms of you observing  
10 without them telling you?

11 A. Sure.

12 Q. Sight, smell, touch?

13 A. Sure. Tobacco smoke on their  
14 breath, a pack of cigarettes in their pocket,  
15 yellow fingers.

16 Q. Yellow teeth?

17 A. We're in the South.

18 Q. Or stained teeth?

19 A. Yes.

20 MS. DESUE: We're in the South, you  
21 said?

22 BY MR. LEGER:

23 Q. Holes in their clothing, that kind  
24 of thing, from cigarette burns?

25 A. Maybe at the VA, but not in my

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1 practice.

2 Q. My real question is that there are  
3 observable features sometimes of cigarette smokers;  
4 correct?

5 A. That's correct.

6 Q. Would, in the ordinary course of  
7 your treatment, you make an observation in the  
8 record if a person has not indicated they're a  
9 smoker to you on the forms or by history, but you  
10 observe characteristics of a smoker?

11 A. No.

12 Q. So the significance to you as a  
13 clinician is the self-reporting aspect; correct?

14 A. Yes.

15 Q. I assume you do not intend to offer  
16 yourself as an expert in pulmonology?

17 A. No, sir.

18 Q. Or in lung cancer?

19 A. No.

20 Q. Or cardiology?

21 A. No.

22 Q. Surgery above the waist?

23 A. No.

24 Q. Do you regularly treat children?

25 A. No longer. I stopped about two

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1 years ago.

2 Q. And why was that?

3 A. Kind of almost turf battles now.

4 Now, there are a sufficient number of pediatric  
5 urologists such as to make it less common that I  
6 would see problems in children, and the — and I  
7 would be only seeing the simple things, like  
8 circumcisions or things like that. More difficult  
9 ones would go off, and I would send them myself, to  
10 the pediatric urologist.

11 Q. Okay. Do you know any of the expert  
12 witnesses in this case?

13 A. None.

14 Q. Do you know Dr. Roy Wiener?

15 A. No.

16 Q. Have you met any of the defendants'  
17 expert witnesses in this case?

18 A. No, I haven't.

19 Q. Do you know Dr. Maltby?

20 A. No.

21 Q. You ever heard of him?

22 A. No.

23 Q. Do you intend to be — have you been  
24 told when the trial in this case will begin?

25 A. No.

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1 Q. Do you understand that this case is  
2 a class action on behalf of all Louisiana smokers?  
3 A. Yes.  
4 Q. And you understand that the members  
5 of the class are seeking to be able to benefit from  
6 a program of smoking cessation?  
7 A. Okay.  
8 Q. Is that your -- did you know that  
9 before I --  
10 A. Yes.  
11 Q. Okay. So you've seen the monitoring  
12 program --  
13 A. Yes.  
14 Q. -- and seen that it has several  
15 parts?  
16 A. Correct.  
17 Q. One is a smoking cessation program;  
18 correct?  
19 A. Correct.  
20 Q. And the other are monitoring or  
21 screening provisions regarding bladder cancer, lung  
22 cancer, coronary artery disease, and COPD, chronic  
23 obstructive pulmonary disease; correct?  
24 A. Correct.  
25 Q. All right. Are you in a position to

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1 offer opinions regarding any of the areas of the  
2 medical monitoring program other than bladder  
3 cancer?  
4 A. No.  
5 Q. Are you familiar with the provisions  
6 of the Guide to Clinical Preventive Services?  
7 A. I've read it.  
8 Q. Is that something that you would  
9 have read ordinarily in your practice?  
10 A. No.  
11 Q. And you read it merely in connection  
12 with testimony in this case; correct?  
13 A. That's correct.  
14 Q. And you read the provisions  
15 regarding recommendations in connection with  
16 bladder cancer?  
17 A. Yes, sir.  
18 Q. And what are those recommendations?  
19 A. Oh, I'd have to read it again.  
20 Q. Okay.  
21 MR. LEGER: Do you have a clean copy  
22 of it?  
23 MS. DESUE: Yes, I do.  
24 BY MR. LEGER:  
25 Q. What do you know about this thing,

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1 this Guide to Clinical Preventive Services?  
2 A. What do I know about it?  
3 Q. Yes, sir.  
4 A. Other than having read it?  
5 Q. Yes, sir.  
6 A. I don't understand the question.  
7 Q. Had you ever heard of this thing  
8 before --  
9 A. No.  
10 Q. -- this case?  
11 A. No.  
12 Q. And so you didn't find it on your  
13 own --  
14 A. No.  
15 Q. -- did you? You didn't look it up  
16 as a research source?  
17 A. No.  
18 Q. You were -- this was given to you by  
19 tobacco lawyers; right?  
20 A. That's correct.  
21 Q. Is -- would you agree that this  
22 Guide to Clinical Preventive Services is not  
23 something that is ordinarily used by practicing  
24 physicians?  
25 MR. WATTLEWORTH: Object to the

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1 form.  
2 A. As a guide, no, but the general  
3 principles within are well accepted.  
4 BY MR. LEGER:  
5 Q. Okay. But I mean -- but in terms of  
6 finding the principles, to determine the  
7 principles, the typical practitioner doesn't look  
8 for this guide --  
9 A. No.  
10 Q. -- is that correct?  
11 MR. WATTLEWORTH: Object to form. I  
12 just want to -- are you talking about any  
13 practitioner or a urologist?  
14 MR. LEGER: I'm talking about in his  
15 observation; right.  
16 BY MR. LEGER:  
17 Q. Okay. Well, let's break it down,  
18 then. Urologists don't -- when they're trying to  
19 think of what are we going to do to try to prevent  
20 disease, they don't go to the Guide to Clinical  
21 Preventive Services, do they?  
22 A. No.  
23 MR. WATTLEWORTH: Object to the  
24 form.  
25 BY MR. LEGER:

31 (Pages 118 to 121)

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1 Q. To your -- you're also an internist;  
2 correct?  
3 A. No, no. I'm a urologist in general  
4 urology only.  
5 Q. You're board-certified in urology?  
6 A. Correct.  
7 Q. And do you have -- in the context of  
8 your experience, do general practitioners and  
9 family practitioners, in general, turn to the Guide  
10 to Clinical Preventive Services to determine the  
11 principles on which they base their practices?  
12 A. They might.  
13 Q. You have no knowledge of it,  
14 correct?  
15 A. No, I don't.  
16 Q. Now, I assume what you read, in  
17 particular, was the provision regarding screening  
18 for bladder cancer, correct?  
19 A. That's correct.  
20 Q. And we're not going to spend a lot  
21 of time on it, but I just want to refer to you that  
22 portion on page 181 -- and this is a copy of what  
23 was provided us by your attorneys -- and that's  
24 the --  
25 MR. WATTLEWORTH: Do you want him to

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1 A. No.  
2 Q. Would you be interested in seeing  
3 any of those documents?  
4 A. If I'm told that they're  
5 particularly interesting or relevant.  
6 Q. By whom?  
7 A. It depends.  
8 Q. How about if I tell you they are?  
9 A. They'd be worth a read.  
10 Q. Okay. Have -- in connection with  
11 your working in the Engles case, after your  
12 deposition, were you requested to do any additional  
13 research or study before testifying at trial?  
14 A. Was I requested?  
15 Q. Yes, sir.  
16 A. I don't think I need to be  
17 requested.  
18 Q. Did you do additional research after  
19 your deposition?  
20 A. Yes.  
21 Q. Okay. In what regard?  
22 A. Just general information about  
23 bladder cancer and --  
24 Q. Do you expect to do any additional  
25 research or study in preparation for testimony at

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1 read it or do you want him to -- are you going to  
2 ask him about a particular portion?  
3 MR. LEGER: Yeah, I'm just going to  
4 ask to the --  
5 BY MR. LEGER:  
6 Q. Do you disagree with the  
7 recommendations under the recommendations in the  
8 recommendations square?  
9 A. Yes.  
10 Q. I'm sorry. Yes, you agree?  
11 A. I agree with the recommendations.  
12 Q. In connection with your opinion,  
13 were you given any internal company documents to  
14 review by any of the tobacco companies --  
15 A. No.  
16 Q. -- or regarding any of the tobacco  
17 companies?  
18 A. No.  
19 Q. You're a subscriber to the Journal  
20 of the American Medical Association?  
21 A. I am.  
22 Q. Have you followed articles or  
23 publications in JAMA regarding the public  
24 disclosure of documents in the Minnesota trial and  
25 documents regarding Brown & Williamson?

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1 this trial, in the Scott case, than what you've  
2 done already?  
3 A. If something new comes across my  
4 desk, yes, I certainly will. In my general reading  
5 of the literature, absolutely.  
6 Q. In the context of what we've  
7 discussed today, has anything that we've talked  
8 about today suggested that you may want to do  
9 additional research?  
10 A. I wouldn't say -- I couldn't say  
11 specifically on what, but, yes, in general, you  
12 know, one keeps up with the literature anyway, and  
13 now that my interest is piqued by this, I certainly  
14 will. I mean, something comes up on bladder tumor  
15 or antigens or something, I -- my interest is going  
16 to be clearly brought to that.  
17 Q. Okay. But, in particular, nothing  
18 that we've talked about today has suggested to you  
19 that you want to look in any particular subject  
20 matter in the context of your testimony; correct?  
21 A. No.  
22 Q. In Florida, when a medical  
23 malpractice case is filed, is it filed in court or  
24 is there some type of administrative procedure?  
25 A. It has to go through a panel of



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1 doctors first, yes.  
 2 Q. Now, did -- in the case of the three  
 3 malpractice cases in which you were a defendant,  
 4 did they go beyond the panel of doctors?  
 5 A. Yes.  
 6 Q. And so they were filed in court?  
 7 A. Yes, they were.  
 8 Q. And so they would be public record?  
 9 A. They are.  
 10 Q. What county would they have been  
 11 filed in?  
 12 A. Hillsborough.  
 13 Q. All three of them?  
 14 A. Yes.  
 15 Q. Are you aware of the fact that the  
 16 jury in the Engles case found that smoking causes  
 17 bladder cancer?  
 18 A. Yes.  
 19 Q. Did you testify only regarding  
 20 bladder cancer?  
 21 A. I did.  
 22 Q. Did you disagree with that verdict?  
 23 A. They're not scientists. They're not  
 24 physicians. For -- in the way that they  
 25 interpreted, I guess, you know, I go along with

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1 them, but as a physician, I know -- and as a  
 2 semi-scientist -- that that actual causation factor  
 3 has not been -- is not satis -- not brought to my  
 4 satisfaction that I would accept it and say that  
 5 smoking definitely causes cancer in and of itself.  
 6 Q. And I know -- and I'm not going to  
 7 quibble with you -- you and the lawyer quibbled  
 8 over the term "reasonable medical certainty." Is  
 9 reasonable medical certainty any different to you  
 10 than reasonable medical probability?  
 11 A. Well, they are two different words,  
 12 probability and certainty --  
 13 Q. Mm-hmm.  
 14 A. -- so they're not equivalent.  
 15 Q. Okay. Would you have an opinion as  
 16 to a reasonable medical probability as to whether  
 17 or not cigarette smoking causes bladder cancer?  
 18 A. As I said about that at that time,  
 19 and I will say now and in the future, there are  
 20 multiple causes for cancer, and at present we  
 21 accept that there is a -- what we call a two-hit  
 22 theory in that you start out with some genetic  
 23 predisposition for it, and then some environmental  
 24 exposure causes the expression of that  
 25 susceptibility so that one thing by itself, no,

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1 doesn't cause cancer.  
 2 Q. Okay. You would agree that  
 3 cigarette smoking is a contributing cause to  
 4 cancer --  
 5 A. It's clearly --  
 6 Q. -- in the bladder, correct?  
 7 A. -- true, yes.  
 8 Q. Would you also agree that cigarette  
 9 smoking can contribute to the development of  
 10 bladder cancer?  
 11 A. Very possibly, yes.  
 12 Q. Have you, in the past, participated  
 13 in any type of a focus group or a mock trial or  
 14 anything of that nature in connection with your  
 15 testimony in either the Engles case or this case?  
 16 A. No.  
 17 Q. Have you been told that you may  
 18 participate in such an activity?  
 19 A. No, I haven't.  
 20 MR. LEGER: I keep trying to think  
 21 of something else. I feel guilty. I think we can  
 22 conclude the deposition at this point.  
 23 MS. DESUE: You -- the only other  
 24 thing is whether you would want to offer the  
 25 rest -- the rest of his file was basically reports

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1 from various experts, review of Dr. Wiener's  
 2 deposition testimony --  
 3 MR. LEGER: Oh, right.  
 4 MS. DESUE: -- if you wanted to  
 5 offer any of those.  
 6 MR. LEGER: Well, yeah. Let me  
 7 spend a couple minutes with you on that.  
 8 BY MR. LEGER:  
 9 Q. Dr. Sartor's report, is there any  
 10 fundamentally that you disagree with in the context  
 11 of Dr. Sartor's report?  
 12 A. This isn't Dr. Sartor's report, is  
 13 it?  
 14 Q. No.  
 15 MR. WATTLEWORTH: Do you have a copy  
 16 of that?  
 17 MR. LEGER: Let's pull it out.  
 18 MS. DESUE: I think it's attached.  
 19 Yeah. Let me just get for you. There we go.  
 20 BY MR. LEGER:  
 21 Q. And I'm going to turn it to the page  
 22 that -- page 5 -- that refers to bladder cancer in  
 23 particular.  
 24 A. Okay.  
 25 MR. WATTLEWORTH: So your question

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1 is, is there anything that he disagrees with?  
 2 MR. LEGER: Yes.  
 3 MR. WATTLEWORTH: So, I mean, he --  
 4 do you want to go ahead and read --  
 5 THE DEPONENT: Okay.  
 6 MR. WATTLEWORTH: -- down through  
 7 that again, if you need to.  
 8 MS. DESUE: I mean, it's all part of  
 9 the record anyway.  
 10 THE DEPONENT: No, I don't have any  
 11 problem with that.  
 12 BY MR. LEGER:  
 13 Q. Okay. Thank you. Have you seen  
 14 reports from Dr. Schoenberg and --  
 15 A. I have.  
 16 Q. -- Dr. Elbert?  
 17 A. I have.  
 18 Q. Anything you -- that you observed  
 19 that you disagree with in their reports?  
 20 A. Again, I'd have to review them.  
 21 Q. I'll give you both of those.  
 22 MR. WATTLEWORTH: Are you going to  
 23 ask him to review Schoenberg's entire report right  
 24 now?  
 25 MR. LEGER: Yeah. And if you want

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1 to take a break --  
 2 MR. WATTLEWORTH: It's like 10 or 15  
 3 pages long. That's why I asked. Actually, let's  
 4 go off the record for a second.  
 5 MR. LEGER: Let's go off the  
 6 record.  
 7 (Discussion off the record.)  
 8 BY MR. LEGER:  
 9 Q. And just for the record, while we  
 10 were off, counsel for the defendant reminded you  
 11 that these reports are expert reports that were  
 12 prepared in this litigation on behalf of the  
 13 defendants, and then you reviewed them off --  
 14 A. I have.  
 15 Q. -- off the record? Anything  
 16 significantly that you disagree with in these  
 17 reports?  
 18 A. No.  
 19 MR. WATTLEWORTH: If I could just  
 20 let the record reflect that he took a fairly brief  
 21 opportunity to review them, and Dr. Schoenberg's  
 22 report is 10 to 15 pages and it's -- you know, the  
 23 minutiae of which he didn't have an opportunity to  
 24 refresh his recollection.  
 25 MR. LEGER: I would agree; he really

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1 skimmed the reports.  
 2 BY MR. LEGER:  
 3 Q. But in any event, your recollection  
 4 is that you did, at one point, study them a little  
 5 bit closer than you just did?  
 6 A. I did.  
 7 Q. And there was no significant  
 8 disagreement that you had with those reports?  
 9 A. That's correct.  
 10 MR. LEGER: I have no further  
 11 questions.  
 12 THE DEPONENT: Okay.  
 13 MR. LEGER: Thank you, Doctor.  
 14 THE DEPONENT: You're welcome.  
 15 MR. WATTLEWORTH: If we could just  
 16 have a couple of minutes to look over my notes  
 17 and --  
 18 MR. LEGER: Sure.  
 19 MR. WATTLEWORTH: -- confer.  
 20 (Discussion off the record.)  
 21 CROSS-EXAMINATION BY MR. WATTLEWORTH:  
 22 Q. Dr. Cockburn, I have just a couple  
 23 of follow-up questions I'd like to ask you.  
 24 Counsel for the plaintiff, a moment ago, asked you  
 25 to look at Dr. Sartor's report, very briefly --

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1 A. Yes.  
 2 Q. -- and asked you if there was  
 3 anything in that report with which you disagreed.  
 4 And just to make sure everything's clear on this  
 5 issue, you are aware that Dr. Sartor is advocating,  
 6 along with the other experts for the plaintiffs,  
 7 that a population of smokers in Louisiana are the  
 8 ones who are going to be screened for bladder  
 9 cancer? In other words --  
 10 A. That's correct.  
 11 Q. -- they will be screened because  
 12 they are smokers or ex-smokers. Is that your  
 13 understanding of what their --  
 14 A. Yes.  
 15 Q. -- approach is?  
 16 A. Yeah.  
 17 Q. Okay. Now, do you agree with that  
 18 proposal?  
 19 A. No, no, and I said so before. Not  
 20 just because they're smokers. I mean, I thought I  
 21 made that point clear, and I didn't pick that up  
 22 again in Dr. Sartor's report. Again, not just  
 23 because they're smokers, but if they had  
 24 hematuria. And hematuria is the defining trigger  
 25 that will then alert the clinician to go and do the

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1 other necessary workup.

2 I don't think that people should be  
3 screened in the way that we've been talking about  
4 screening just because they're smokers. The yield  
5 on that is much, much, much too low to -- it's  
6 certainly not cost effective -- to justify it.

7 Q. And we -- you discussed this a  
8 little bit earlier, but, again, I want to make sure  
9 this is clear, because I'm not sure it was. Is it  
10 your opinion that the urinalysis itself is the  
11 initial screening tool?

12 A. Is the screening tool.

13 Q. Is the screening tool.

14 A. Yes.

15 Q. Okay.

16 A. And when we're talking about  
17 screening, that's what the urinalysis does, is to  
18 screen for those individuals who might be  
19 susceptible to developing some other abnormality,  
20 and cancer is one of them. But I accept that as a  
21 screening tool. None of the others have the lack  
22 of expense, ease of facility of use, and wide  
23 applicability as urinalysis.

24 Q. And after urinalysis, if the person  
25 who is screened has -- is positive for hematuria,

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1 workup.

2 Q. Okay. We talked earlier -- counsel  
3 for the plaintiff asked you a lot of questions  
4 about NMP-22 as an adjunct to cytology,  
5 cystoscopy. Is there any kind of a consensus in  
6 the medical community as to the appropriateness of  
7 using NMP-22 as an adjunct?

8 A. Yes. I think the consensus now is  
9 that it is not of value to be used in this  
10 context. It has potential, as do several other  
11 tests, but the variability in its detection ability  
12 in terms of its sensitivity, in terms of its  
13 specificity, are too broad to recommend it to be  
14 used in this fashion.

15 As I mentioned before, the most --  
16 the best way that it can be used right now is for  
17 those individuals who have been found to have  
18 bladder cancer and have been treated, and now  
19 you're treating them for follow-up and you want to  
20 decide whether or not I want to do a cystoscopy on  
21 this individual in follow-up for recurrence of  
22 their cancer. That's when the NMP seems to have  
23 better validity in its use. But as an open-ended  
24 screening-type test, it's far, far too insensitive  
25 to be used in that context at this time.

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1 blood in the urine, at that point, the other tests  
2 that you would prescribe for that patient --  
3 cytology, cystoscopy, IVP -- those are follow-up  
4 tests --

5 A. Those are follow-up tests --

6 -- to determine --

7 A. -- and they're not screening tests.

8 Q. And you don't -- and that procedure  
9 of beginning with a urinalysis and then follow-up,  
10 depending on what you find -- in other words, if  
11 you find hematuria, then you follow up --

12 A. Right.

13 Q. -- with those three methods -- those  
14 are, again, not dependent on whether you're a  
15 smoker --

16 A. No.

17 Q. -- or an ex-smoker --

18 A. That's correct.

19 Q. -- or a never smoker?

20 A. That's correct.

21 Q. I think you stated earlier, it's  
22 something that -- urinalysis is something that you  
23 should have on a yearly basis as part of your --

24 A. If you've never been a smoker and  
25 you have blood in your urine, you get the same

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1 Q. Is it accurate to say, then, that in  
2 the urologic community, it is not the standard of  
3 care --

4 A. No.

5 Q. -- to utilize NMP-22 as a follow-up  
6 device when you've got hematuria in the blood --

7 A. It's --

8 Q. -- following the urinalysis?

9 A. It's not the standard of care for  
10 follow-up for hematuria or for bladder cancer.  
11 It's not the -- it's presently being studied as  
12 such, but it's not the standard of care to be used  
13 at all, in any context, whether just hematuria or  
14 if a patient has defined history of bladder  
15 cancer.

16 It's one of those new things that  
17 has come along, and it's under evaluation. And  
18 possibly within the next five years, we're going to  
19 know more about it or it'll be refined better so  
20 that we can -- it will have greater utility, but  
21 right now, it doesn't.

22 MR. WATTLEWORTH: That's all we've  
23 got.

24 MR. LEGER: Okay. Doctor, I've got  
25 a few more questions.

138	1 REDIRECT EXAMINATION BY MR. LEGER: 2 Q. Doctor, you provided us with a 3 number of medical articles -- 4 A. Yes, sir. 5 Q. -- and which you indicated you had 6 relied upon in the context of your opinions; 7 correct? 8 A. Correct. 9 Q. And a number of those reported 10 testing of a number of the diagnostic tools or 11 monitoring tools or screening tools or tests that 12 you spoke about on the second page of your report; 13 correct? 14 A. That's correct. 15 Q. And those included vascular 16 endothelial growth, P-53, BAT Stat (sic), 17 Telomerase, NMP-22, and the others that you'd 18 suggested; correct? 19 A. That's correct. 20 Q. Would you agree that, largely, this 21 literature is supportive of the usefulness of those 22 tools in detecting bladder cancer? 23 A. No. 24 MR. WATTLEWORTH: Are you talking 25 about all those tools?	140	1 hematuria? 2 A. No. 3 Q. You don't think that it predicts 4 bladder cancer -- 5 A. No. 6 Q. -- in people with hematuria? 7 A. No. 8 Q. All right. Now, you will recall 9 that my earlier hypothetical had nothing to do with 10 people that already have bladder cancer; correct? 11 A. No, then I don't recall that -- 12 Q. Okay. The record will speak for 13 itself. 14 So you also agree, Doctor, that 15 screening is recommended in people who are high 16 risk to exposure to environmental carcinogens; 17 correct? 18 A. That's correct. 19 Q. And the screening you would 20 suggest -- the initial lining of screening -- would 21 be urinalysis; correct? 22 A. That's correct. 23 Q. And once screened for hematuria, and 24 a finding of hematuria, there are secondary 25 screening opportunities that you have; correct --
139	1 MR. LEGER: Yes. 2 MR. WATTLEWORTH: Okay. 3 A. No, no, no. I think what the 4 articles say is that there is an ongoing search for 5 something that would be better than cytology. At 6 the present time, there is none. None are better 7 than cytology. If you take cytology and you 8 compare it against each one of those individually, 9 the cytology is still a better test. 10 BY MR. LEGER: 11 Q. Now, you earlier testified that if 12 you take NMP-22 and cytology together -- 13 A. Yes. 14 Q. -- they both complement each other; 15 correct? 16 A. You have an adjunctive benefit; you 17 have more information. 18 Q. So you would agree, of course, in 19 the context of attempting to diagnose bladder 20 cancer, if you did NMP-22 and cytology together, 21 you have a better predictive potential than using 22 cytology alone; correct? 23 A. For people who have already had 24 cancer of the bladder. 25 Q. What about people who have	141	1 MR. WATTLEWORTH: Object to the 2 form. 3 Q. -- including the use of the 4 cytology? 5 MR. WATTLEWORTH: Object to the 6 form. 7 A. Well, it's no longer called 8 screening at that point. 9 BY MR. LEGER: 10 Q. What is it called at that point? 11 A. That's called a workup. 12 Q. Okay. And what is a workup? 13 A. A workup is where you have a defined 14 abnormality and now you're looking for the cause of 15 that abnormality. 16 Q. Okay. 17 A. So the abnormality is just blood in 18 the urine. 19 Q. Okay. So the urinalysis itself is 20 the screen in the population where you haven't 21 defined the abnormality yet; correct? 22 A. That's correct. 23 Q. Okay. Now you have found an 24 abnormality -- 25 A. Mm-hmm.

<p>142</p> <p>1 Q. -- and you're simply trying to --</p> <p>2 you're trying to limit and differentiate between</p> <p>3 what disease or illness may be causing the</p> <p>4 abnormality; correct?</p> <p>5 A. Or none.</p> <p>6 Q. Or none, or to exclude --</p> <p>7 A. Right.</p> <p>8 Q. -- disease or illness; correct?</p> <p>9 A. Yeah.</p> <p>10 Q. Now, do any of these studies that</p> <p>11 you show -- that you present with your -- in your</p> <p>12 reference guide suggest that NMP-22 is not</p> <p>13 effective in attempting to identify the abnormality</p> <p>14 in hematuria?</p> <p>15 A. None of them speaks to any of them</p> <p>16 as being ineffective. It's a relative degree of</p> <p>17 effectiveness in terms of what you want from a</p> <p>18 screening test. Okay? A screening test, you want</p> <p>19 high sensitivity to pick out all of the positives</p> <p>20 in a population, and you want -- and specificity so</p> <p>21 that all the positives that you pick out are --</p> <p>22 have what you're looking for.</p> <p>23 In that regard, all of those tests</p> <p>24 show promise. And most of the articles point out</p> <p>25 that if you combine two of them, then they approach</p>	<p>144</p> <p>1 predictive value of NMP-22?</p> <p>2 A. Again, it's very variable. Just</p> <p>3 because it's negative, it doesn't mean that you</p> <p>4 don't have a tumor.</p> <p>5 Q. Right.</p> <p>6 A. And we're --</p> <p>7 Q. That's true of many tests; correct?</p> <p>8 A. That's true of many tests, but --</p> <p>9 Q. Including cytology?</p> <p>10 A. That's correct.</p> <p>11 Q. And in any event, the articles speak</p> <p>12 for themselves --</p> <p>13 A. That's correct.</p> <p>14 Q. -- in the context of what they</p> <p>15 found?</p> <p>16 A. (Deponent nods head.)</p> <p>17 Q. The article by Marta</p> <p>18 Sanchez-Carbayo, Comparative Sensitivity of</p> <p>19 Urinary -- is it CYRFA 21-1, etc.? -- that's an</p> <p>20 article provided to you by lawyers for the tobacco</p> <p>21 companies or is that one you found yourself?</p> <p>22 A. What's the journal?</p> <p>23 Q. It's from --</p> <p>24 A. Is that Journal of Urology?</p> <p>25 Q. That is Journal of Urology.</p>
<p>143</p> <p>1 some of the accuracy of cytology. If you combine</p> <p>2 NMP-22 with the cytology 33 test, then you have --</p> <p>3 you approach it. Now you have two tests, so two of</p> <p>4 those together may equal the one that you're using</p> <p>5 now. So what we want is something better than</p> <p>6 cytology.</p> <p>7 Q. So if you -- and as you testified</p> <p>8 before, if you combine NMP-22 and cytology, you</p> <p>9 have a modality that's even better than cytology</p> <p>10 alone; correct?</p> <p>11 A. In specific patients, those who have</p> <p>12 had cancers before that you've treated and you're</p> <p>13 treating -- you're now looking for recurrence.</p> <p>14 Q. Okay. You believe that NMP-22 is</p> <p>15 not effective in identifying the source of</p> <p>16 abnormality in persons who did not have cancer</p> <p>17 already?</p> <p>18 A. No, because that test is only</p> <p>19 looking for cancer cells, and so it is not as</p> <p>20 effective as we would like it to be.</p> <p>21 Q. Okay. And what is the -- or do you</p> <p>22 know what the positive predictive value of NMP-22</p> <p>23 is?</p> <p>24 A. Oh, it's all over the place.</p> <p>25 Q. Okay. What is the negative</p>	<p>145</p> <p>1 A. I think that's one of mine.</p> <p>2 Q. What's the relevance of a high</p> <p>3 negative predictive value?</p> <p>4 A. High -- it's a strike against the</p> <p>5 test. The test is inaccurate in terms of high</p> <p>6 false negatives.</p> <p>7 Q. And how does that relate to</p> <p>8 sensitivity to detect malignancy?</p> <p>9 A. Well, that means that the</p> <p>10 sensitivity is less than desirable.</p> <p>11 Q. Okay. If the sensitivity is a</p> <p>12 hundred percent for invasive disease, is that good</p> <p>13 or is that bad?</p> <p>14 A. That's good for invasive disease.</p> <p>15 Q. And if it's 70 percent overall, what</p> <p>16 does that mean?</p> <p>17 A. That means that it's very good for</p> <p>18 invasive disease, very poor for early stage</p> <p>19 disease.</p> <p>20 Q. For superficial tumor --</p> <p>21 A. Or --</p> <p>22 Q. -- or early stage invasive disease?</p> <p>23 A. Or early stage invasive disease.</p> <p>24 Q. Doctor, would you agree that</p> <p>25 painless hematuria occurs in about 85 percent of</p>

<p>146</p> <p>1 patients with bladder cancer?</p> <p>2 A. Yes, I would accept that.</p> <p>3 Q. Would you also agree that nearly all</p> <p>4 patients with bladder cancer have at least</p> <p>5 microhematuria?</p> <p>6 A. Yes, sir.</p> <p>7 Q. How much does a urinalysis cost?</p> <p>8 A. Medicare will pay you \$6 for it</p> <p>9 sometimes.</p> <p>10 Q. Will Medicare pay for cytology?</p> <p>11 A. Yes.</p> <p>12 Q. What will they pay?</p> <p>13 A. I don't know. I don't know how much</p> <p>14 of it they will pay. I really don't know.</p> <p>15 Q. About how much does cytology cost?</p> <p>16 A. It's about \$120.</p> <p>17 Q. Would \$40 be a good price for</p> <p>18 cytology?</p> <p>19 MR. WATTLEWORTH: Object to the</p> <p>20 form. Are you talking about Medicare</p> <p>21 reimbursement?</p> <p>22 MR. LEGER: I'm talking about cost.</p> <p>23 MR. WATTLEWORTH: Oh.</p> <p>24 MR. LEGER: Simply cost.</p> <p>25 MR. WATTLEWORTH: Oh, if it cost</p>	<p>148</p> <p>1 A. I shouldn't make a statement about</p> <p>2 this, because I'm totally in the dark as to what</p> <p>3 the costs of cytology are across the board. Some</p> <p>4 places -- I'm sure there are places that you can</p> <p>5 get it for less than \$120, so I don't know. \$60,</p> <p>6 \$80. I don't know.</p> <p>7 Q. You would agree that the reason that</p> <p>8 cytology is not -- or one of the reasons that</p> <p>9 cytology is not recommended for screening or</p> <p>10 monitoring is the high cost; correct?</p> <p>11 A. We use it for monitoring, but we</p> <p>12 don't use it for screening.</p> <p>13 Q. What's the difference? I guess</p> <p>14 that's what we need to talk -- what's the</p> <p>15 difference between monitoring and screening?</p> <p>16 A. Okay. When you have an unknown</p> <p>17 population that you're surveying, that's screening.</p> <p>18 Q. Okay.</p> <p>19 A. When you have a known population</p> <p>20 that has the disease, then you're monitoring them</p> <p>21 for the disease recurrence.</p> <p>22 Q. What about a population that has a</p> <p>23 high risk for the disease?</p> <p>24 A. You're screening.</p> <p>25 Q. Okay. So you consider that you're</p>
<p>147</p> <p>1 \$40?</p> <p>2 MR. LEGER: Mm-hmm.</p> <p>3 THE DEPONENT: With the same degree</p> <p>4 of accuracy?</p> <p>5 BY MR. LEGER:</p> <p>6 Q. Is there different types of</p> <p>7 cytology?</p> <p>8 A. Different types of people who are</p> <p>9 reading it, and that's what you're depending on.</p> <p>10 Q. Okay.</p> <p>11 A. And so you know, if you're going to</p> <p>12 pay someone cheaply, you might not get the best</p> <p>13 person there, so --</p> <p>14 Q. Presumably, you can get volume</p> <p>15 discounts for tests; right?</p> <p>16 A. Presumably.</p> <p>17 Q. You would agree, even in medicine?</p> <p>18 A. Yeah, well, I think the \$120 is</p> <p>19 probably the volume discount.</p> <p>20 Q. Okay. But if you could get it for</p> <p>21 \$40, that would be pretty cost effective; right?</p> <p>22 A. Yeah.</p> <p>23 Q. Assuming everything else?</p> <p>24 A. See, I'm --</p> <p>25 Q. Assuming competency and otherwise?</p>	<p>149</p> <p>1 not monitoring until you've already found some</p> <p>2 evidence of the disease?</p> <p>3 A. That's correct.</p> <p>4 Q. Okay. Well, is there -- is that a</p> <p>5 definition that's accepted in the scientific</p> <p>6 literature?</p> <p>7 A. I would think so.</p> <p>8 Q. Is it -- would you agree that the</p> <p>9 terms "screening" and "monitoring" are used</p> <p>10 oftentimes --</p> <p>11 A. Interchangeably?</p> <p>12 Q. -- interchangeably?</p> <p>13 A. I think inaccurately so, yes.</p> <p>14 Q. Okay. But you would agree,</p> <p>15 generally in the medical profession, it may be</p> <p>16 often used interchangeably -- the two terms?</p> <p>17 A. I don't think by doctors, by</p> <p>18 clinicians.</p> <p>19 Q. Okay. Where can we find the</p> <p>20 definition of those two terms?</p> <p>21 A. I don't think you're going to get a</p> <p>22 hard-and-fast one. You know, you monitor someone</p> <p>23 for their heart disease, you monitor their</p> <p>24 hypertension, but if you have an asymptomatic</p> <p>25 population, you're not monitoring it; you're</p>

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1 basically just checking to see if they have  
2 hypertension.  
3 Q. Have the lawyers for the tobacco  
4 companies shown you the legal definition of medical  
5 monitoring -  
6 A. No.  
7 Q. - under Louisiana law?  
8 A. No.  
9 Q. I would like - I'm going to show  
10 you that, and I want - I mean -  
11 MR. WATTLEWORTH: You're talking  
12 about the Bourgeois case?  
13 MR. LEGER: The Bourgeois case.  
14 MR. WATTLEWORTH: Yeah, that  
15 outlines the factors for recovery of medical  
16 monitoring?  
17 MR. LEGER: Right.  
18 BY MR. LEGER:  
19 Q. Have you seen the factors in the  
20 Bourgeois case in Louisiana?  
21 A. I don't know the Bourgeois case. I  
22 don't know if I did.  
23 MR. WATTLEWORTH: Let's go off the  
24 record ~~for a second~~.  
25 (Discussion off the record.)

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1 BY MR. LEGER:  
2 Q. ~~Discussion~~ off the record, we  
3 discussed - you have been shown - Counsel has  
4 indicated that you have been shown the factors,  
5 without identifying, apparently, to you the name of  
6 the case -  
7 A. Yes.  
8 Q. - that we consider make up the law  
9 of medical monitoring in the state of Louisiana; is  
10 that correct?  
11 A. Yes.  
12 Q. In what way were you shown that?  
13 A. Well, I have to tell you, I don't  
14 even remember the context in which I was shown it,  
15 so -  
16 Q. Were you given a piece of paper?  
17 A. You're identifying something that I  
18 can't place at all in my memory, because you keep  
19 mentioning the Bourgeois case, and I don't know it  
20 as such. If it was shown to me as the Louisiana  
21 medical monitoring statute or whatever, then  
22 perhaps I was - I had seen it, but I don't  
23 remember it.  
24 Q. So that we're very clear, I'm - I  
25 am not trying to suggest what you have been shown;

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1 I'm trying to find out what you have been shown or  
2 told -  
3 A. I haven't seen it to -  
4 Q. - by lawyers.  
5 A. - to refresh my memory. I don't  
6 know.  
7 Q. Were you given a piece of paper with  
8 something on it that you were told, This is medical  
9 monitoring in Louisiana, or were you told it  
10 orally?  
11 A. I was given quite a bit of  
12 information from Sartor, Weiner, Schoenberg, as  
13 well as the literature excerpts, but I don't  
14 remember this one as such.  
15 Q. Okay. I mean, you've basically  
16 given us - if they showed you something that was  
17 medical monitoring, they took it back?  
18 A. If you let me see it, I might be  
19 able to remember.  
20 Q. Okay. Well, you obviously - I  
21 promise you, you weren't given this.  
22 A. Okay.  
23 Q. This is mine.  
24 A. This is an excerpt from the -  
25 Q. This is an excerpt -

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1 A. - statute?  
2 Q. This is an excerpt from the case.  
3 A. Case.  
4 Q. From the case, yeah, in Louisiana  
5 that I have prepared for my purposes in very large  
6 print that I can even read without my little  
7 glasses. But what I'm trying to find out first,  
8 before we even get to this, is, what was shown to  
9 you or told to you the law is?  
10 A. I don't recollect.  
11 Q. Okay. Let me ask you this: Would  
12 you agree that the program recommended by the  
13 doctors and scholars in Louisiana for medical  
14 monitoring with respect to bladder cancer - and  
15 that is urinalysis for hematuria, then NMP-22 and  
16 cytology - is different from that normally  
17 recommended in absence of exposure to toxic  
18 chemicals?  
19 A. It is different, yes.  
20 Q. Okay. You have no reason to believe  
21 that the doctors that put this together in  
22 Louisiana and elsewhere were not qualified  
23 physicians, do you?  
24 A. No.  
25 Q. Okay. You also agree that

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1 procedures exist that make the early detection of  
2 bladder cancer possible; correct?

3 A. Yes.

4 Q. You also agree that cigarette  
5 smoking presents a significant exposure to  
6 carcinogens found in cigarette smoke; correct?

7 MR. WATTLEWORTH: Object to the  
8 form.

9 A. Given the volume and duration.

10 BY MR. LEGER:

11 Q. Okay. You agree that cigarette  
12 smoking — it's common, unequivocal medical and  
13 scientific opinion that cigarette smoke contains a  
14 large number of known carcinogens in humans; is  
15 that correct?

16 MR. WATTLEWORTH: Object to the  
17 form. Argumentative.

18 A. That cigarette smoke contains —  
19 yes — carcinogens, yes.

20 BY MR. LEGER:

21 Q. And these carcinogens are in  
22 particulate form; correct?

23 A. Yes.

24 Q. You would agree that a person who  
25 smokes cigarettes is at an increased risk of

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1 Q. So you don't agree or believe that  
2 five pack years of cigarettes is significant  
3 exposure; correct?

4 A. Significant for the development of  
5 bladder cancer?

6 Q. Yes, sir.

7 A. It depends on the susceptibility of  
8 the individual.

9 Q. Okay. And we're talking about  
10 individuals in total. We don't know  
11 susceptibility, do we?

12 A. No, we don't.

13 Q. All we know is that approximately 50  
14 percent of bladder cancers have been related to  
15 smoking cigarettes; correct?

16 MR. WATTLEWORTH: Object to the  
17 form.

18 A. I don't like generalizations like  
19 that because it's one factor in an individual's  
20 total exposure in his daily life. Is that  
21 individual also a truck driver? Does he also work  
22 in an industry in which there are other  
23 carcinogens? It's hard to say.

24 BY MR. LEGER:

25 Q. Are you asking me?

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1 contracting bladder cancer and other serious  
2 diseases over a person who has never smoked  
3 cigarettes; correct?

4 MR. WATTLEWORTH: Object to the  
5 form. Vague.

6 A. Depending on the number of  
7 cigarettes per day per year.

8 BY MR. LEGER:

9 Q. How many cigarettes per day? How  
10 many years?

11 A. It would seem to me, from what I've  
12 read, over 15 cigarettes a day for an extended  
13 period of years.

14 Q. How many?

15 A. Without — I would say it would have  
16 to be over ten years.

17 Q. Okay. And where do you get that  
18 figure from?

19 A. I picked it out of my head, based on  
20 generalizations that I'd seen before for exposure  
21 to tobacco.

22 Q. Okay. That's opposed to five pack  
23 years of cigarettes? Are you familiar with the  
24 term "pack years"?

25 A. A pack a day for five years, yeah.

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1 A. Well, I'm saying that that's why  
2 that figure is inaccurate.

3 Q. Are you questioning the scientific  
4 literature?

5 A. I'm questioning the interpretation  
6 of the scientific literature when based only on one  
7 factor.

8 Q. Including Campbell's Urology;  
9 correct?

10 A. When based on only one factor, yes,  
11 absolutely.

12 Q. But you would agree — and I'm not  
13 asking you to base it only on one factor, I'm  
14 asking you to consider that the epidemiological  
15 data and the conventional scientific thought  
16 suggests that cigarette smoking is a factor — a  
17 risk factor in 50 percent of bladder cancers.

18 MR. WATTLEWORTH: Object to the  
19 form.

20 BY MR. LEGER:

21 Q. Would you agree with that?

22 A. Fifty percent of bladder cancers in  
23 this country?

24 Q. Yes, sir, in the United States of  
25 America.



<p>158</p> <p>1 A. No —</p> <p>2 Q. You disagree with that?</p> <p>3 A. — no. Absolutely, because</p> <p>4 they're — when you include 50 — when you say 50</p> <p>5 percent of cancers, you're including superficial</p> <p>6 cancers as well as invasive cancers, and it would</p> <p>7 seem to me that superficial cancers are not clearly</p> <p>8 identified — well, I don't even know that. I</p> <p>9 can't even say that.</p> <p>10 Q. Right. And I'm not saying</p> <p>11 anything. I'm just asking you if, one, you agree</p> <p>12 that there is a body of scientific thought that</p> <p>13 suggests that cigarette smoking is a substantial</p> <p>14 risk factor in 50 percent of bladder cancers.</p> <p>15 A. In a substantial amount of bladder</p> <p>16 cancers, yes.</p> <p>17 Q. Okay. Would you agree that a</p> <p>18 cigarette smoker's risk of contracting bladder</p> <p>19 cancer is greater than the risk of contracting</p> <p>20 bladder cancer had he not smoked?</p> <p>21 A. Yes.</p> <p>22 Q. Would you also agree that the risk</p> <p>23 of a cigarette smoker in contracting a serious</p> <p>24 disease, such as bladder cancer, is greater than</p> <p>25 the chance of the members of the public at large of</p>	<p>160</p> <p>1 similar in wording to that document?</p> <p>2 A. I can't say that I remember exactly.</p> <p>3 as such.</p> <p>4 Q. Okay. Do you recall being told that</p> <p>5 these are basically the factors of medical</p> <p>6 monitoring in Louisiana?</p> <p>7 A. No.</p> <p>8 Q. Okay. Just one other thing. You</p> <p>9 talked about, both in your deposition and your</p> <p>10 trial testimony in Engles, and to some very limited</p> <p>11 degree here, that there are a couple of steps in</p> <p>12 the development — a couple or a few steps in the</p> <p>13 development of bladder cancer; correct?</p> <p>14 A. Okay, yes.</p> <p>15 Q. One of those steps requires or</p> <p>16 involves an impact of a carcinogenic substance with</p> <p>17 the cells of the bladder; is that correct?</p> <p>18 A. That's correct.</p> <p>19 Q. And is it — would you agree that it</p> <p>20 is the general agreement in the scientific</p> <p>21 community regarding bladder cancer that the impact</p> <p>22 of the carcinogen on the epithelium of the bladder</p> <p>23 is a significant event in the development of</p> <p>24 bladder cancer?</p> <p>25 MR. WATTLEWORTH: Object to the</p>
<p>159</p> <p>1 developing a disease, including nonsmokers?</p> <p>2 MR. WATTLEWORTH: Object to the</p> <p>3 form.</p> <p>4 A. Yes.</p> <p>5 BY MR. LEGER:</p> <p>6 Q. Would you agree that there is a</p> <p>7 demonstrated clinical value in the early detection</p> <p>8 of bladder cancer?</p> <p>9 A. Yes.</p> <p>10 MR. LEGER: I don't have any further</p> <p>11 questions.</p> <p>12 MS. WIMBERLY: Just one minute,</p> <p>13 Walter.</p> <p>14 MR. LEGER: Well, actually, I do.</p> <p>15 BY MR. LEGER:</p> <p>16 Q. I just want to — just one question,</p> <p>17 and the question is yes or no. Is — I'm showing</p> <p>18 you a document, which I have produced, which I</p> <p>19 believe is a summary of the factors of Bourgeois,</p> <p>20 and which I think counsel has agreed basically is</p> <p>21 word for word out of the — for what it is, and</p> <p>22 just ask you if you have seen a document which</p> <p>23 outlines those factors in identical wording.</p> <p>24 A. I may have. I don't remember.</p> <p>25 Q. You've seen a document that is</p>	<p>161</p> <p>1 form.</p> <p>2 BY MR. LEGER:</p> <p>3 Q. Assuming that you eventually find</p> <p>4 bladder cancer.</p> <p>5 A. Yes.</p> <p>6 Q. I understand carcinogens can impact</p> <p>7 the epithelium and never get — you never get</p> <p>8 bladder cancer; right?</p> <p>9 A. That's correct.</p> <p>10 Q. Assuming there is — you say that</p> <p>11 there has to be some earlier event to the</p> <p>12 development of the carcinogen in order for bladder</p> <p>13 cancer to develop; right?</p> <p>14 A. That's correct.</p> <p>15 Q. Something else had to have happened</p> <p>16 first, maybe a genetic predisposition, some other</p> <p>17 impact or insult or trauma; correct?</p> <p>18 A. Right; that's correct.</p> <p>19 Q. And then eventually a carcinogen</p> <p>20 impacts the walls of the epithelium; correct?</p> <p>21 A. That's correct.</p> <p>22 Q. And then there may be other events</p> <p>23 or factors, but — and then you end up with bladder</p> <p>24 cancer; correct?</p> <p>25 A. That's correct.</p>

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1 MR. LEGER: No further questions.  
 2 MS. WIMBERLY: One minute, Walter.  
 3 THE VIDEOGRAPHER: Do you want to go  
 4 off the record?  
 5 MR. WATTLEWORTH: Just for a second,  
 6 yes.  
 7 (Discussion off the record.)  
 8 MR. WATTLEWORTH: We have no further  
 9 questions, but I would like to reserve the right  
 10 for him to read and sign his deposition.  
 11 MR. LEGER: Oh, absolutely.  
 12  
 13 (Deposition adjourned at 1:05 p.m.)  
 14  
 15  
 16  
 17  
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1 JURAT  
 2 I, ALDEN G. COCKBURN, M.D., do  
 3 hereby certify that I have read the foregoing  
 4 transcript of my testimony, taken on October 26,  
 5 2000, and have signed it subject to the following  
 6 changes:  
 7 PAGE LINE CORRECTION  
 8 \_\_\_\_\_  
 9 \_\_\_\_\_  
 10 \_\_\_\_\_  
 11 \_\_\_\_\_  
 12 \_\_\_\_\_  
 13 \_\_\_\_\_  
 14 \_\_\_\_\_  
 15 \_\_\_\_\_  
 16 \_\_\_\_\_  
 17 \_\_\_\_\_  
 18  
 19  
 20 DATE:  
 21  
 22 Sworn and subscribed to before me on this day  
 23 of  
 24  
 25 NOTARY PUBLIC

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1 CERTIFICATE  
 2  
 3 I, Cynthia L. Varney, a Shorthand Reporter  
 4 and Notary Public of the State of Florida, do  
 5 hereby certify that prior to the commencement of  
 6 the examination, the witness was sworn by me to  
 7 testify the truth, the whole truth, and nothing but  
 8 the truth.  
 9 I do further certify that the foregoing is  
 10 a true and accurate transcript of the testimony as  
 11 taken stenographically by and before me at the  
 12 time, place, and on the date hereinbefore set  
 13 forth.  
 14 I do further certify that I am neither of  
 15 counsel nor attorney for any party in this action  
 16 and that I am not interested in the event nor  
 17 outcome of this litigation.  
 18  
 19  
 20  
 21 Notary Public of the State of Florida  
 22  
 23 Florida Commission No. CC929457  
 24 Expires: 4/19/04  
 25

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